Preventing unsafe abortion to reduce maternal mortality

Report of the regional meeting
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Abbreviations

ANM  Auxiliary Nurse Midwife
BCC  Behaviour Change Communication
BKKBN  WHO Collaborating Centre for Family Planning and Reproductive Health, National Family Planning Coordination Board (Indonesia)
CAC  Comprehensive Abortion Care
D&C  Dilation and Curettage
DGFP  Directorate General of Family Planning
DPR  Democratic People’s Republic (of Korea)
EmOC  Emergency Obstetric Care
EVA  Electric Vacuum Aspiration
IEC  Information, Education and Communication
IPPF  International Planned Parenthood Federation
IU(C)D  Intrauterine (contraceptive) Device
MBBS  Bachelor of Medicine and Surgery
MR  Menstrual Regulation
MSI  Marie Stopes International
MTP  Medical Termination of Pregnancy (Act)
MVA  Manual Vacuum Aspiration
NGO  Non-Governmental Organization
PAC  Oost-Abortion Care
PCPNDT  Preconception and Prenatal Diagnostic Techniques (Act)
PDR  (Lao) People’s Democratic Republic
PHC  Primary Health Care
PIP  Programme Implementation Plan
PoC  Products of Conception
PSI  Population Service International
RTI  Reproductive Tract Infection
SEAR  South-East Asia Region
SLCOG  Sri Lanka College of Obstetricians and Gynaecologists
SRH  Sexual and Reproductive Health
STI  Sexually Transmitted Infection
UNFPA  United Nations Population Fund
WHO  World Health Organization
A number of declarations and treaties signed in the last two decades highlight the growing consensus that unsafe abortion is an important cause of maternal mortality. Despite this, an estimated 21.6 million abortions continue to be performed unsafely each year, resulting in the death of an estimated 47,000 women and disabilities for an additional 5 million. Most of these deaths and disabilities could have been prevented through access to family planning services, sexuality education and provision of safe abortion if the full extent of the law had been implemented. In almost all countries, the law permits abortion to save a woman’s life, and in most countries it is permitted in order to preserve the physical and/or mental health of the woman. In countries where abortion is restricted, access to safe abortion is the prerogative of the rich, while poor women have little choice but to resort to illegal and often unsafe abortion, resulting in death or morbidity arising from complications. What is disconcerting is that globally, about 3.2 million unsafe abortions occur every year among girls aged 15–19 years – most of which occur in developing countries. Adolescents are particularly vulnerable and are less likely to be able to prevent pregnancy or access legal and safe abortions, if they want, and hence present late for an abortion.

Responding to the need for evidence-based best practices for providing safe abortion, the World Health Organization (WHO) updated its 2003 publication entitled Safe abortion: technical and policy guidance for health systems. While the legal, regulatory, policy and service delivery contexts may differ from country to country, the recommendations and best practices provided in the revised guidance aim to enable evidence-based decision-making with respect to safe abortion care.

This regional meeting was convened to disseminate the revised WHO guidance. Participants came from 14 countries, including Member States in the South-East Asia Region as well as Cambodia, the Lao People’s Democratic Republic (PDR) and Pakistan. The country participants included representatives from ministries of health, WHO collaborating centres in maternal and reproductive health, nongovernmental organizations (NGOs) providing abortion and family planning services as well as professional organizations and institutions.
2

Inaugural Session

2.1 Address by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region

Dr Arvind Mathur, Medical Officer, WHO South-East Asia Regional Office, welcomed the participants to the meeting and invited Dr Lin Aung to deliver the inaugural address on behalf of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region. In his address, Dr Samlee talked about the need for action at multiple levels to achieve the Millennium Development Goal to reduce maternal mortality. Women die because of complications during pregnancy, childbirth and during the postpartum period. Among an estimated 210 million pregnancies worldwide, 62% are planned and as many as 38% are unintended. The main reasons for unintended pregnancies are lack of knowledge and limited access to family planning services. Despite impressive gains in contraceptive use, unintended pregnancies still occur and therefore there continues to be a need for safe abortion services. Women die because they seek to terminate unintended pregnancy, and in the absence of appropriate and safe abortion services, they seek unsafe abortion. Of the estimated 21.6 million unsafe abortions worldwide, Asia accounts for 10.8 million and reports 13% maternal mortality associated with unsafe abortion.

The Regional Director highlighted that many women who experience complications following an unsafe abortion do not seek medical care, as they either do not perceive these complications as serious, do not have access to financial resources, or fear abuse, ill-treatment or legal reprisal. Teenage pregnancies and unsafe abortions among young women aged 15–24 are a cause of alarm. Referring to new technologies and emerging
evidence, Dr Samlee noted that attention should be focused on preventing unintended pregnancies and providing safe, comprehensive abortion care (CAC). There is growing consensus that unsafe abortion is an important cause of maternal mortality and should be prevented through access to family planning services, sexuality education and provision of safe abortion to the full extent of the law.

WHO plays a crucial role in developing norms and standards and in assisting Member States in strengthening the capacity of their health systems. The Regional Director hoped that the Member States would be able to develop or adapt national strategies to implement the updated evidence-based technical and policy guidance in their respective countries. Welcoming all the delegates from the South-East Asia Region and other countries, he expressed his appreciation to the Government of Nepal for hosting the meeting (Annex 1: Speech by Dr Samlee Plianbangchang).

2.2 Address by Dr Pravin Mishra, Honorary Secretary, Ministry of Health and Population, Government of Nepal

In his opening remarks, Dr Pravin Mishra, Honorary Secretary, Ministry of Health and Population, Government of Nepal, noted that abortion was not only a medical challenge but also a social, legal, cultural and political challenge. In advocating to reduce maternal mortality rates in the country, one way might be to put in place innovative mechanisms to increase contraceptive prevalence rates and thereby bring people on board to reduce maternal mortality due to unsafe abortion. Nepal has implemented some innovative programmes like Maternal Protection Programme, which has proven to be cost-effective with positive outcomes. Dr Pravin also talked about the need to address the challenge, particularly in the public health sector, of misuse of certain drugs, including misoprostol and oxytocin. He hoped that this regional meeting would help in identifying new ways to deal with such challenges, and integrate abortion services within the grassroots service delivery level. This meeting also provided an opportunity for countries to learn from each other’s experiences and to find solutions to the challenges they each faced.
2.3 Opening remarks: Dr Narimah Awin, Regional Advisor, Maternal and Reproductive Health

Dr Narimah Awin, Regional Advisor, Maternal and Reproductive Health, was invited to give the opening remarks on behalf of the South-East Asia Region and share the objectives of the meeting with the participants. She highlighted the challenges of unsafe abortion and resulting maternal mortality in the region. The updated Safe abortion technical and policy guidance for health systems, generated from evidence based research, brings into focus a human rights approach to service delivery and formed the basis of the meeting objectives.

The general objective of the meeting was to disseminate the updated WHO safe abortion guidance. The specific objectives of the meeting were:

1. to discuss the current global, regional and country situation of abortion services; and
2. to facilitate the development of country-level action plans for promotion of safe abortion services.

Welcoming the participants, Dr Bela Ganatra, Lead Specialist, Preventing Unsafe Abortion, WHO headquarters, said the meeting being hosted in Nepal was opportune as the country was celebrating 10 years of liberalized abortion services. Nepal was thus a case study for others to learn from its experiences and the processes undertaken to liberalize abortion services.
3

Setting the scene: country, regional and global overview of preventing unsafe abortion

The first technical session aimed at setting the scene included a country, regional and global level overview of preventing unsafe abortion. To understand each country’s specific context of abortion provision, participants were divided into four groups and a chair, a co-chair and rapporteur were identified. Each country made a presentation within its group and shared information on demographic data, existing abortion laws, penalties for providing unsafe abortion or abortion outside the purview of the law, standards and guidelines for abortion and post-abortion care (PAC), challenges and recommendations to make abortion safe and accessible.

Group 1 : Bangladesh, Bhutan, Indonesia (Annex 2.1: Group 1 presentations)
Group 2 : India, Nepal, Sri Lanka (Annex 2.2: Group 2 presentations)
Group 3 : Cambodia, Maldives, Pakistan, Timor-Leste (Annex 2.3: Group 3 presentations)
Group 4 : Democratic People’s Republic of Korea, Myanmar, Lao PDR, Thailand (Annex 2.4: Group 4 presentations)

The country presentations highlighted the challenges faced in providing safe and PAC. In four countries, namely Bangladesh, Myanmar, Sri Lanka and Timor-Leste, abortion services are very restricted and can be provided only to save the life of a woman. Other countries, where the law is more liberal, the provision of safe abortion is restricted for various reasons. Challenges at the demand level included: cultural and social barriers; stigma attached to abortion and related care; lack of awareness of legality of abortion among women as well as other stakeholders; limited reproductive health awareness; and difficult geographic terrain restricting access to services. At the supply level, the challenges include: inadequate funding from the government to provide safe abortion services; lack of adequate number of facilities or trained personnel; non-availability of essential drugs and equipment; and providers’ misconceptions, biases and negative attitudes towards clients and referrals.

In order to ensure safe abortion services, it appeared that countries need to undertake strong advocacy both for providers as well as for policy-makers and political leaders. There is also a need to ensure availability of adequate facilities and trained personnel and therefore gaps in pre- and in-service training curricula should be addressed. It was also suggested that where mid-level providers are not included as service providers, attempts should be made to train them as abortion providers as they are the first point of referral for women. It is also imperative to ensure that abortion services are available at all public
health facilities, including the lower level service delivery points, and that an adequate and regular supply of drugs and equipment is assured.

After the country level presentations of the four groups, Dr Narimah Awin shared the regional situation on preventing unsafe abortion. Her presentation focused on data highlighting the magnitude of unsafe abortion, the legal status in the 11 Member States of the South-East Asia Region, and the availability of services or lack thereof in the South and East Asia regions. WHO maintains a database on unsafe abortion. The data, collected through various sources, are published regularly and give indications on the incidence and prevalence of abortion worldwide. As per 2008 estimates, of the 210 million pregnancies worldwide, 80 million pregnancies resulted in abortion, 43.8 million of which were induced, and as many as 21.6 million were unsafe. The resulting maternal mortality due to unsafe abortion is 13% globally.

Dr Narimah then highlighted the legal and service delivery aspects of abortion services in the South and East Asia regions. While all countries permit abortion to save a woman’s life, the laws are restrictive in Bangladesh, Indonesia, Myanmar, Sri Lanka and Timor-Leste. Democratic People’s Republic (DPR) Korea, India, Nepal and Thailand permit abortion for a range of social, economic and psychological reasons. However, not all countries have national standards and guidelines available for abortion service provision. Dr Narimah closed by noting that the dynamics of abortion services are complex, as are the interrelationship between negative social perception, public acceptance, low political will and restrictive laws and environment. Laws to reduce maternal mortality due to unsafe abortion in the region therefore need to be strongly advocated (Annex 3: Unsafe abortion in the South-East Asia Region).

Dr Bela Ganatra presented the global scenario and highlighted the incidence of abortion worldwide. Of the 43.8 million induced abortions worldwide, 21.6 million are unsafe with 1 in 10 pregnancies ending in an unsafe abortion. Even though induced abortion rates have decreased globally, the proportion of unsafe abortions has increased from 44% in 1995 to 49% in 2008. While abortions have become less unsafe, they still account for 13% of all maternal deaths. Whether abortion laws are more restrictive or less restrictive, induced abortion will continue to exist. WHO’s second edition of Safe abortion: technical
and policy guidance for health systems includes the latest evidence-based guidance on clinical care. In the process of updating the guidelines, WHO involved multi-disciplinary experts from the world over to identify areas that needed updating, and undertook a systematic review of evidence. The guidance emphasizes that preventing unsafe abortion has several components, including sexuality education, access to contraception, safe abortion and care for complications. It also looks at the human rights perspective of access to safe services and the need to adapt and adopt newer technologies for safe abortion services. The document takes a holistic approach to service delivery by involving a range of stakeholders including policy-makers, programme managers, service providers, advocates and human rights experts. It also emphasizes the need to ensure that services are available at the primary care level, and beyond the first trimester. In addition, the care provided must be sensitive to the woman’s needs and respect her dignity, autonomy, choice and confidentiality (Annex 4: Unsafe abortion – a global scenario).
Abortion in adolescents: situation and challenges

Dr Neena Raina, Regional Advisor, Child and Adolescent Health shared insights about the situation and challenges of adolescent abortion in the South-East Asia Region. She noted that, globally, about 3.2 million unsafe abortions occur every year among girls aged 15–19 years, mostly in developing countries (2008 estimates). A number of factors contribute to adolescent pregnancy, notably level of education, urban/rural residence, ethnicity, cultural values and norms including gender imbalance and socioeconomic status. Adolescents are a disadvantaged group and are less likely to be able to prevent pregnancy, or to be able to access a legal and safe abortion if they wanted to terminate a pregnancy. Hence, they are likely to report late – usually in the second trimester – increasing the complications of abortion. Dr Raina suggested that to ensure safe and timely access to abortion care services for adolescents, this need should be addressed through primary, secondary and tertiary prevention (Annex 5: Abortions in adolescents – can we afford to ignore them?).

To identify legal and policy barriers, four small groups reviewed and deliberated a case study. Each group was assigned a designated facilitator and identified a rapporteur to present the group discussion to the plenary session. Some of the key points raised related to:

- **Consent taking:** There was a suggestion that minors should be permitted to undergo abortion without parental/guardian consent because of fear of “honour killing”, pregnancy resulting from rape or incest. It is the health provider’s responsibility to provide abortion services and an underage girl should not be refused for want of consent. Consent taking from a partner or parent restricts timely access to abortion services.
• **Abortion services for minors:** A health provider has ethical and moral obligations towards a minor seeking abortion services. Is the provider ethically bound to make this service available or can it be refused? Participants considered that if the provider has a conscientious objection, it is his/her duty to refer the minor to another service provider. In case the minor cannot undergo an abortion and is forced to give birth to the child, the provider should seek the help of civil society to care for the child.

• **Role of professional bodies and civil society organizations:** Professional bodies and civil society organizations play an important role in sensitizing various stakeholders, particularly in countries where abortion laws are restrictive and create barriers to safe services. The overall environment is also important – active civil society, solid public-private partnerships, strong contraceptive programmes, and a high level of education and health systems all contribute to safe abortion services.

• **Interpretation of laws:** While the law may be liberal, its interpretation may be restrictive and procedural barriers and administrative hurdles limit the effectiveness of ensuring access to safe abortion.

• **Counselling:** Counselling is not mandatory but should be tailored to suit the specific needs of the woman. The content of the counselling was discussed, e.g. whether it should address what the woman wants or what the provider feels is necessary. It was suggested that non-scientific information should not be shared with the client, like potential infertility as a consequence of abortion. Pre-abortion information should be mandatory and counselling should be voluntary. The client should be given information on the abortion procedure and family planning methods.

The session highlighted the need to respect the rights of the client and ensure that services provided are timely and without any prejudice.
Overview of Safe abortion: technical and policy guidance for health systems, Chapter 4 – Legal and policy considerations; and introduction to the human rights approach

Mr. Rajat Khosla, Policy Coordinator (Health), Amnesty International, gave an overview of the legal and policy considerations as indicated in Chapter 4 of the revised Guidelines. He provided participants with a brief introduction to the international human rights framework. Relating this framework to abortion, he said that monitoring bodies, and regional and national courts have given increasing attention to the issue of abortion in the past decades, including maternal mortality due to unsafe abortion, criminalization of abortion and restricted legislation that leads to women to seek illegal and unsafe abortion. The new Guidance reflects the significant development and changes since the publication of the first WHO edition in the clinical, service delivery and human rights aspects of safe abortion. Explaining the factors that restrict access to safe and timely abortion, he emphasized that laws and policies on abortion should protect women’s health and their human rights; there is a need to remove regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care, and to create an enabling environment to ensure that every woman who is legally eligible has ready access to safe abortion care (Annex 6: Safe abortion: technical and policy guidance for health systems, Chapter 4).

The presentation was followed by an interactive session with three panel members in a question–answer forum. The panellists were Dr Sim-Poey Choong, Chair, Asia Safe Abortion Partnership, Malaysia; Ms Sapna Pradhan Malla, Lawyer/Advocate and former member of Constituent Parliament, Nepal; and Professor Kamheang Chaturachinda, Emeritus Professor and President, Women’s Health and Reproductive Rights Foundation of Thailand, Thailand. Each member answered questions related to:

- laws, abortion and human rights highlighting legal and other restrictions in accessing abortion services, processes of legal reforms undertaken and their success in ensuring better access to services;
- barriers to safe abortion care to include affordability of safe abortion services, restricting available methods of abortion and lack of regulatory approval for essential medicines, lack of confidentiality and privacy and requirement of third party authorization from husband for accessing services;
- human rights and enabling policy environment and service delivery to include issues related to challenges faced in bringing about policy reforms, discrimination on grounds of socioeconomic status, race and ethnicity in accessing services, limited access to abortion services by adolescents and other vulnerable groups.
A summary of the discussion is provided below.

Dr Choong said that Malaysia does not have a high rate of abortion but that access to safe services is limited by other factors, including stigma both from the woman’s as well as the providers’ perspective. The available guidelines are not very clear. The existing law states that abortion is a criminal act, with exceptions for trauma to mental and physical health. However, the private sector is taking advantage of this for commercial reasons. This has also resulted in the problem of “baby dumping” because of fear of stigma and provider hesitation in providing services for fear of the label “abortionist”. In identifying vulnerable groups, Dr Choong said that Muslim married women require the husband’s consent to seek abortion, even if they are divorced, because the husband has the right over the child. In case the pregnancy is out of wedlock, despite a provision of confidentiality, providers sometimes inform religious leaders and the woman may be fined and jailed. This delays access to safe services and these women may be forced to approach illegal providers. Another vulnerable group is adolescents, particularly those below 18 years of age. These adolescents often go to another city or access help from NGOs. Malaysia has very restricted access to abortion services and there is a constant fear that the administration will close down available facilities on trivial grounds, such as low ceilings or doors not being wide enough.

Dr Pradhan highlighted that Nepal had a very high maternal mortality rate due to unsafe abortion. Women were either left to die from consequences of unsafe abortion or were criminalized and imprisoned. The Center for Research on Environment Health and Population Activities undertook a study of women imprisoned because of abortion or related offences. This study showed that women had no right to refuse sex if married, marital rape was not considered a crime, and the health consequences of unsafe abortion had to be suffered since women have no right to abortion. It was only in the 1990s, when the democratic movement started in Nepal, that rights became an issue and NGOs, civil society organizations and academicians all became part of this movement. This was also the time when advocacy for safe abortion started. As per the bill registered in 1997 and passed in 2002, abortion was permitted only up to 12 weeks and only for married women. Sex selective abortion was considered an issue and was made illegal and brought into the law. However, there were no standards or guidelines and this required another set of advocacy activities to ensure that standards were developed to guide abortion services in the country.
Challenges continue to exist in making abortions safe and affordable. For example, awareness about legality among women is low; the cost of abortion is high thereby making access for poor rural women difficult; even though abortion is legal, it is nested within the chapter on homicide and this creates some misunderstanding about its legality. There is a need to have laws to promote safe abortion. She cited the case where a man objected to legalizing abortion saying that it denies a man his right. However, the court rejected his plea, noting that the right to decide whether to continue the pregnancy or not resides only with the woman. Some legal barriers that were overcome by Nepal include expanding the provider base to include staff nurses and Auxiliary Nurse Midwives (ANM) for provision of abortion services and ensuring that free, affordable, safe services are available at public health facilities. Abortion needs to be brought within the framework of reproductive rights and steps are being taken to implement this.

Professor Chaturachinda emphasized that a service provider must treat the pain of his patients as his/her own and look after the patient as if she was your mother. If safe services are to be available, there is a need to go to the medical schools and teach the young students that abortion should not be treated as a stigma. There is a lot of ambivalence about abortion in Thailand and as the politicians change, the civil servants also change and do what the politicians want them to do. Thailand is a patriarchal society and this makes it difficult to change mindsets, including that of women as they finds it difficult to stand up for their rights to obtain abortion, as even women are fraught with stigma.

Abortion costs are high in the country. If a woman has the resources and is educated, she can access safe services but if she is poor and uneducated, she is forced to access the underground illegal abortion providers and suffer the consequences. If safe and free abortion was made available, fewer women would die of sepsis and complications of unsafe abortion. There is a dilemma in society: while there is restricted availability of medical abortion pills, access to Viagra is relatively easy. Abortion should be considered as an integral part of reproductive health, as if a woman can deliver a baby or have access to contraception, she should also have access to abortion. The attitude of providers needs to be changed as women are often ill-treated or abused in public hospitals and often cannot afford the fees of private providers. This delays timely access to safe services. There is a need to go back to basics and teach the students how to behave with patients.

In the discussion that followed the panel session, participants raised a number of issues to make provision of safe abortion possible within the human rights context. For example, the need to increase awareness about the legality of abortion and to budget for implementation of laws; to advocate for increased government responsibility for providing services and thus reduce the large percentage of abortion services being provided by the private sector; the need to change the mindset of providers and ensure provision of abortion services; and to create awareness not only among service providers but also law makers and law enforcing agencies so that they are able to discern between spontaneous and induced abortion and lawful abortion. Lack of awareness of laws, lack of access to safe services and limited government provision of abortion services were deemed to be the most important barriers to safe services. Undertaking advocacy activities on research-based evidence was considered a necessary action point.
This session focused on the clinical guidelines in the revised publication. Dr Nathalie Kapp, WHO headquarters, traced the processes undertaken by WHO in developing the revised clinical guidelines. She mentioned that since the first edition in 2003, a considerable amount of new data have been produced and published relating to clinical, service-delivery, legal and human rights aspects of providing safe abortion care. Therefore, preparation for the revision of the guidelines included the conduct of several new, as well as updated systematic reviews. The substantial revisions reflect changes in methods of abortion and related care, service delivery as it applies to the availability and use of new methods, and application of a human rights framework for policy-making and legislation related to abortion, among other topics. No changes have been made to recommendations in the 2003 guidelines for which there is no new evidence (Annex 7: The process of developing the WHO guidelines for safe abortions, second edition).

This was followed by a presentation by Dr Suneeta Mittal, India on the revised clinical guidelines. The guidelines focus on pre-abortion care; methods of abortion, including offering prophylaxis to clients and cervical preparation for women undergoing surgical evacuation; PAC; and guidance for local adaptation. Post-abortion contraception should be routinely offered to the client, who should be encouraged to adopt at least one method prior to discharge from the facility. National standards and guidelines for safe abortion care should be evidence-based and periodically updated in line with WHO guidance, and should aim to achieve equitable access to good-quality care. New policy and programme interventions should reflect evidence-based best practices. Dr Mittal emphasized that the training of abortion providers must ensure that they have the competency to deliver good-
quality care in accordance with national standards and guidelines. This requires ongoing supervision, quality assurance, monitoring and evaluation (Annex 8: Safe abortion: technical and policy guidance for health systems, Chapter 2 – Clinical recommendations).

A panel discussion, moderated by Dr Suchitra Dalvie of Asia Safe Abortion Partnership in India, highlighted the challenges for implementing the clinical guidelines. The panel members were: Dr Helena von Hertzen, Senior Advisor on Medical Abortion, Concept Foundation, Switzerland; Ms Hilary Bracken, Gyunity, United States of America; Dr Chanda Karki, Kathmandu Medical College, Nepal; Dr Poonam Shivkumar, Mahatma Gandhi Institute of Medical Sciences, India; and Dr Rubina Sohail, South Asia Federation of Obstetricians and Gynaecologists, Pakistan. The issues deliberated were:

- **What specific changes within the system and overarching strategies are needed for implementation?**

  Dr Sohail underlined the enormous challenge in implementing the guidelines. She suggested that the main stakeholders who provide services should be identified to ensure that guidelines are followed. Once the WHO guidelines are in place, the next step will be to develop national standards and guidelines to be shared with government officials and other stakeholders. Dr Sohail also suggested that the guidelines be incorporated in the curricula of medical education as it is important that medical students learn to distinguish between spontaneous and induced abortion. Professional organizations play a crucial role in this process, not only within the medical profession but lawyers, law enforcing agencies and politicians as they need to be sensitized about the legality of abortion. The medical professionals needs to ensure that the guidelines are followed by preparing competency-based training modules for doctors as well as mid-level providers based on the country-specific context. Dr Sohail reiterated the need to change the mindset and attitudes of providers. She felt that mid-level providers could be used to provide counselling, PAC and gestational age assessment for eligibility. There is also a need to ensure that facilities and an adequate supply of drugs and equipment are available, that a budget allocation is in place as well as mechanisms for monitoring and supervision.

- **What practices entrenched within the system need to be changed?**

  Dr Von Hertzen emphasized the need to adapt the guidance to suit the local and national context. Earlier it was believed that if a woman seeking termination was under 18 years old and the gestation age is 10 weeks, misoprostol should be used for cervical ripening as this avoids complications. But this decision should be based on the local context and the provider’s experience. For second trimester abortion, there is little evidence on the use of mifepristone, but studies are ongoing to assess the efficacy of the drug for priming.

- **Have providers moved away from D&C (Dilation and Curettage) to MVA (Manual Vacuum Aspiration)?**

  Dr Karki said that despite availability of new technology, D&C continues to be the
preferred method of abortion. The current pre-service curriculum is not updated to include vacuum aspiration, although in Nepal there is a strong move to update the curricula. However, there is resistance from senior professionals, which needs to be addressed so that the younger professionals learn from the older generation who should be their role models. Nepal brought about a change in the government policies based on evidence. This said, the providers, particularly in rural areas, do not always have ready access to data or evidence. The question arises, therefore, of how to keep them abreast of developments in the field.

• **What research studies show alternative ways of follow-up?**

Ms Hillary Bracken shared her insights on the new and ongoing research projects that aim to assess the efficacy of different methods of follow-up, particularly after a medical abortion. She indicated that the recent guideline states no requirement for follow-up or ultrasonography (USG), which is a significant change in the protocol followed to date and has implications, particularly for places where abortion care is scarce. There are new ways of self-assessment and assuring the provider that the abortion is complete. For example, women can receive a checklist to assess their condition, which includes symptoms like bleeding and symptoms of pregnancy. Research studies are ongoing about the efficacy of the new low sensitivity pregnancy test to assess the completion of abortion.

• **What are the issues related to providing family planning services to women?**

Dr Shivkumar said that post-abortion contraception counselling is the most important aspect of abortion care. There is a need to undertake value clarification among providers so that they offer a choice of contraception and not force the woman to adopt one method. The provider must explain all the methods to her, answer her queries if any and then let her decide.

Dr Kari added that Nepal does not have 100% family planning and hence there continues to be a need for abortion services. Both these components of reproductive health should be brought together. Male involvement is a must and thus awareness about reproductive health of women should be created among men.

• **How does one ensure the quality of drugs?**

Dr Von Hertzen said that this was a complicated but important issue. There are instances of counterfeit drugs in the market that do not contain adequate amounts of misoprostol. While WHO has a prequalifying process in place, this is not always adhered to in developing countries. Concept Foundation is helping companies to produce drugs as per international standards. Mifepristone is very stable, while misoprostol is not very stable, sensitive to humidity and hence requires good quality raw materials to produce.
• **How restrictive is the abortion law in Pakistan and what is the impact of the non-formal sector providing abortion services?**

Dr Sohail explained that the abortion law in Pakistan was very broad since abortion is permissible to save the life of the woman and to preserve her physical/mental well-being. This gives providers a broad umbrella, although abortion is only provided sporadically. Some country-specific scenarios exist where legality may not be an issue, but where other laws create restrictions. For example, sex selection and abortion is a major issue and providers may fear persecution even when they are within the boundaries of current legal provisions.

Dr Shivkumar said that sex selective abortion is a double-edged sword and the Preconception and Prenatal Diagnostic Techniques Act (PCPNDT) has created restrictions in provision of abortion services in India. The country has seen a steep fall in the sex ratio (of boys to girls) and while prenatal sex selection and abortion is a legally punishable offence, the practice continues. Increasingly, providers are refusing to carry out such services for fear of being subjected to police enquiry and legal procedures, the police often playing the role of authority. This has been a major barrier in provision of safe and timely abortion services.

• **How can women's safety be ensured while not restricting availability of medical abortion drugs?**

Dr Sohail noted that, while misoprostol was available over the counter in Pakistan, there are no instructions for use of the drug or what should be done in case of complications. Each country needs to decide what is best, i.e. whether the drug should be available only on prescription or over the counter. A suggestion was to undertake research to develop an implementation strategy for availability of medical abortion drugs.

The plenary was followed by comments and questions from participants. Some of the points raised included the terminology and labelling used to define abortion – spontaneous abortion, induced abortion, legal abortion and illegal abortion. This may create ambiguity among stakeholders. It was felt that women who present at a facility with an incomplete abortion after inducing their abortion at home should not be labelled abortion seekers, since all facilities can provide PAC while only registered facilities can provide abortion services, at least within Indian context. As to whether an intrauterine contraceptive device (IUCD) should be inserted immediately after the procedure or after the first menstrual cycle, participants felt that the provider was the best person to decide. There was a suggestion that abortion care could be integrated within RTI/STI (Reproductive Tract Infection/Sexually Transmitted Infection) and cervical screening during the post-abortion counselling period. As far as assessing the completion of abortion by examination of Products of Conception (PoC) is concerned, it was suggested that, while it is up to the expertise of the provider, a visual examination of the PoC is essential to ensure that there are no retained products.
7

Overview of Safe abortion: technical and policy guidance for health systems, Chapter 3 – Establishing and strengthening abortion services

7.1 Introduction: Mr Vinoj Manning, Ipas, India

The presentation made by Mr Vinoj Manning, Country Director, Ipas India first emphasized safe abortion services, showing that guidelines, training, financing and programme management were the key components for provision of quality CAC services. Mr Manning made a direct link between good legal access to abortion and high quality and safety of services. He also stressed the importance of integrating abortion services into health systems, and described safe abortion as a group of services comprising accurate information, non-directive counselling, treatment of complications, and contraceptive services inclusive of information and referrals. Apart from health providers, the involvement of other stakeholders such as teachers, elected representatives and gatekeepers, lawyers, law enforcers, is also important. Attention should be paid to the special needs of vulnerable groups like adolescents, rape victims and survivors, and conscientious objection must be taken into consideration. Similarly, country-specific guidelines must be based on country-specific evidence to optimize safety, quality and accessibility. Based on these guidelines, facilities and providers must be equipped accordingly and competency-based training modules developed. Mr Manning indicated that since most doctors and trained nurses are located in urban areas, and in the light of available evidence, there is an urgent need to reallocate responsibilities and include mid-level providers as abortion service providers (Annex 9: Safe abortion: technical and policy guidance for health systems, Chapter 3 – an overview).
Following Mr Manning’s presentation, participants were divided into four groups; each covered a particular aspect of delivery of abortion services with a lead presenter and designated facilitator to moderate the discussions. The group work aimed to learn from the experiences of the presenters and to identify challenges and suggest ways to overcome these for each of the following topics.

7.2 Evidence-based standards and guidelines: Dr Tapash Ranjan Das, Bangladesh

Dr Das’s presentation highlighted the situation in Bangladesh. According to the Bangladesh Demographic and Health Survey 2007, 29% of all births are unplanned, and 45% of all unplanned pregnancies end in Menstrual Regulation (MR) or illegal abortion. MR and abortions are underreported, though estimates indicate that about 900,000 MR procedures are done every year. Bangladesh’s MR programme has been a collaborative effort between the Government and NGOs, the former providing the training facilities and logistic support, including MVA kits, while the latter took responsibility for coordinating and conducting the training programmes for government service providers. Challenges faced in service delivery include a high rejection rate of MR; women presenting at >10 weeks of gestation, i.e. beyond the legal permissible limit; poor monitoring and supervision; and inadequate provision of post-abortion and post-MR contraception.

In addition, there is lack of community awareness, a perceived conservative religious background which is not in favour of abortion/MR, biased provider attitudes and weak linkages between other reproductive health services and abortion/MR. The presentation highlighted a number of new initiatives undertaken by the Government including strengthening the national MR programme for reduction of maternal mortality and morbidity. Based on the lessons learnt, Dr Das recommended stronger coordination between the government, NGOs, professional bodies and academia; closer linkages with other reproductive health services, especially contraceptive services; establishment of an effective management information system; decentralization of provision of MR and PAC services by trained mid-level providers; and lastly, creation of community awareness on safe abortion and MR services (Annex 10.1: Evidence-based standards and guidelines on menstrual regulation services – issues, challenges, barriers, key lessons).

The presentation was followed by a discussion during which challenges faced by the different countries represented in the group were shared. The main barriers to access were the absence of national level standards and guidelines; the denial of abortion services even though legal; non-availability of services at the primary health care centre; and non-availability of medical abortion. To overcome these challenges, it was proposed that the WHO guidelines be adopted in the respective countries and implemented through civil society organizations. A need was also expressed to educate legal and community stakeholders (Annex 11.1: Group 1 report)
7.3 Service delivery, setting up, monitoring, equipment and drug availability: Dr Pritha Biswas, Marie Stopes International (MSI), India

Dr Biswas’s presentation highlighted the various components of service delivery that include awareness, affordability, management of complications and referrals, post-abortion contraception, demedicalization, evidence-based practice, capacity-building, supervision and clinical updates, task-shifting and decentralization. Some of the challenges cited by Dr Biswas were the interpretation of law by service providers; restrictive environment leading to exploitation and stigma; and use of outdated practices like D&C and hysterotomy in restrictive settings. In addition, awareness is lacking about existing laws, for example in India where there is confusion between the Medical Termination of Pregnancy (MTP) Act and the Preconception and Prenatal Diagnostic Techniques (Prohibition of Sex Selection) (PCPNDT) Act, which in turn restricts access to second trimester abortion. There is also a need to continuously update policy, guidelines and standards based on new evidence available, provide increased access to second trimester abortion and ensure that medical abortion drugs are registered in all countries. Suggestions to improve service delivery include advocating for changes in laws and policies, increasing awareness about the correct interpretation of the law, undertaking community-level activities that promote women’s rights and decision-making and reducing stigma, providing PAC and developing PAC policy, guidelines and standards (Annex 10.2: Establishing and strengthening abortion services – setting up, service delivery, monitoring, drugs and equipment availability).

The group discussion that followed debated the challenges highlighted in the presentation above. Suggested ways forward included the need for legal protection, especially in restrictive settings, for the providers; establishment of adverse events management schemes; creation of community-level awareness; setting up of public–private partnerships to ensure quality services; accessibility and affordability of services especially for poor and vulnerable groups; strong referral systems – both inbound (through strong community mobilization and demand generation) and outbound (to higher centres for complications) and follow-up of referral cases; integration of services both at the level of training and service delivery (which is more important and challenging) (Annex 11.2: Group 2 report).

7.4 Training: pre- and in-service, competency-based, curricula, assessment and quality assurance: Dr Sangeeta Batra, Ipas, India

Dr Batra shared her experiences as a trainer and talked at length about the four essential components of training – curriculum development, competency-based training, pre/in-service training and assessment and quality assurance. In curriculum development, the best practices include developing a learner-centred curriculum based on adult learning principles, which should have a structure and involve objective analysis through pre- and post tests. The best approach would be a mix of methods – didactic sessions followed by clinical practicum and hands-on training. Competency-based training requires hands-on experience with pelvic models or live cases and extensive use of checklists. Some of the challenges for this would be the trainer–trainee ratio, lack of adequate time and case load,
skills loss if the trainee does not start providing service immediately after training, and finally the training only addresses knowledge and skills and not attitudes. For pre-service training to be effective it has to be precisely designed, while in-service training should be more comprehensive and provide repeated exposure to achieve better outcomes.

Best practices in quality assurance include monitoring visits by higher authorities, linking of training to operationalization of services, and periodic refresher workshops for trainers and providers. However, some challenges are an emphasis on activities rollout at the expense of quality; overworked trainers; a high trainer attrition rate; and changing trainers’ attitudes and biases (Annex 10.3: Training: Lessons learnt and challenges).

The group suggested the need to select appropriate training sites and participants and ensure competency-based training. One trainer can teach 7-8 trainees at a time and in order to provide quality training, it is imperative to maintain this ratio. Monitoring the training and getting regular feedback also help in maintaining quality training. Post-training follow-up is also essential to assess whether the skills learnt are being used, and for supervision and mentoring (Annex 11.3: Group 3 report).

7.5 Decentralizing abortion services to primary level: Dr Indira Bassnet, Ipas, Nepal

Dr Bassnet shared the experience of Nepal and talked about decentralizing abortion services to primary level. A number of studies have been undertaken in Nepal to improve access to safe abortion services. One study looked at the feasibility of extending abortion services to the community level while another looked at the feasibility and safety of providing medical abortion services in the public sector and at NGO service delivery facilities. A further study moved beyond existing Safe Abortion Sites and aimed to assess whether provision of medical abortion up to nine weeks by mid-level providers was the same as doctors in terms of safety and efficacy. The findings of these studies, shared by Dr Bassnet, were positive and reiterated that, where permitted, mid-level providers can provide safe, low technology medical abortion for women independently from doctors. Based on this, a number of interventions were undertaken. At the demand level, community-level interventions used IEC (information, education and communication) strategies to increase awareness about abortion services. On the supply side, providers were given programmatic support, regular clinical monitoring, and mentoring (Annex 10.4: Decentralizing abortion services to the primary level).

The group recommended that every country has to address policy-level barriers to expand the law on abortion and remove the financial barriers that restrict access to abortion. Capacity-building needs to be undertaken to ensure the quality of service and value clarification of service providers on abortion. The attitudes of existing service providers also need to be changed to permit mid-level providers as service providers (Annex 11.4: Group 4 report).
7.6 **Stepping forward through abortion laws, policies and procedural order to service delivery: Dr Kiran Regmi, Ministry of Health and Population, Government of Nepal**

Dr Regmi, in her presentation, highlighted Nepal’s journey in liberalizing abortion. She talked at length about the milestones of abortion, abortion laws and policies, the procedural orders that came about in the country, steps taken to expand CAC services and future directions. While Nepal has made significant progress towards making safe abortion possible, Dr Regmi pointed to the challenges faced in expanding services. Examples given were inadequate health facilities and trained personnel; issues relating to monitoring of medical abortion drugs availability and use; difficult geographic terrain making access difficult; political instability; cost of abortion services; limited access to modern contraception; and low levels of awareness about safe abortion. To overcome some of these challenges, ways forward include provision of skilled birth attendants and CAC training to Bachelors of Medicine and Surgery (MBBS) doctors prior to their deployment, training more mid-level service providers including ANM, and updating policy, guidelines, standards, manuals and procedures (Annex 12: Establishing safe abortion services in Nepal).
Field visits

Thanks to the organizers of the regional meeting, in collaboration with the Ministry of Health and Population, Government of Nepal and partners in Kathmandu, field visits were arranged to show participants the work being done in the country towards providing safe abortion services. Visits were made to facilities of the government, the private sector, those supported by organizations like Ipas and NGO-managed facilities such as Marie Stopes International and the Family Planning Association of Nepal. (Annex – 13: Field Visit)
Sharing good practices and country experiences in facilitating safe abortion services

The objective of this session was to share best practices and country-level experiences of partners in providing abortion services in the region.

9.1 Dr Anu Kumar shared Ipas experiences in decentralization and scale-up of abortion services through partnership. She talked about the role of Ipas as a catalyst and facilitator for integrating abortion care in health systems; in expanding CAC and appropriate technologies; developing innovative methods in community access and behaviour change communication (BCC); and undertaking research to provide the evidence base for practice and policy. Ipas believes in forming partnerships with obstetric-gynaecology societies, MSI, Population Service International (PSI), and International Planned Parenthood Federation (IPPF) member associations, women’s organizations, civil society and other networks. It also works with the Government in strengthening abortion services in the region (Annex 14.1: Decentralization and scale-up of abortion services through partnerships).

9.2 Dr Karthik Srinivasan, IPPF, shared best practices on increasing access to abortion services through advocacy and service delivery. Talking about policy advocacy in South Asia, he highlighted that IPPF engages with parliamentarians to support sexual and reproductive health (SRH) services, including safe abortion, and supports law reform and policy approvals on access to safe abortion. IPPF has developed a Law and Obstacles Tool that can be used effectively to assess a country situation. This allows the user to explore and understand laws, regulations and extra-legal obstacles relating to abortion, identify opportunities to increase access, and challenge the argument that “abortion is illegal” when it is not. IPPF best practices include reaching the poor and the marginalized, strengthening partnerships for access to disadvantaged individuals and working closely with communities through a range of service delivery points – hospitals, clinics and satellite centres – to provide integrated SRH services (Annex 14.2: Increasing access to abortion services through advocacy and service delivery).

9.3 Good practices, experiences and challenges from MSI programmes in providing safe abortion services across Asia were shared by Dr Bethan Cobley. She highlighted the key principles of MSI, i.e. to save lives by bringing family planning and reproductive health care to the world’s poorest and most vulnerable women and men; to foster partnerships with governments, existing private health-care providers and other agencies to deliver services; to strengthen national health systems; and to provide training, improve health policies, and share expertise.
MSI also undertakes activities to educate and empower women to make their own choices, and reaches out to underserved communities such as refugees or those affected by disasters. Innovations, e.g. social franchising, insurance and voucher schemes, are also an important aspect of MSI’s key principles (Annex 14.3: Saving lives and delivering choice – Working with governments to provide safe abortion and post-abortion care services in Asia).

9.4 Dr Jyoti Vajpayee shared PSI’s commitment to reducing maternal mortality through safe abortion. PSI, through its various activities, believes in increasing access to safe abortion services within the legal framework of countries, improving PAC services, informing and educating women and increasing access to family planning. The strategies used are partnership with governments to support national strategic priorities, distributing misoprostol to health facilities and pharmacies for PAC, and placement and detailing of medical abortion and/or misoprostol for safe abortion/PAC (Annex 14.4: PSI’s commitment to reducing maternal mortality through safe abortion).

Participants brought up the following issues in plenary discussion:

- Safety associated with abortion provision by mid-level providers: in some countries mid-level providers are legal providers of abortion services up to a limited gestation age, while in others they are integrated within the community and their role is solely to mobilize women to come to the health, and generally NGO facilities.
- Ways to increase access to medical abortion were discussed. It could be provided in any clinic, including satellite clinics with providers available 24x7. In such a system, obstetricians/gynaecologists would visit the facility to provide ongoing supervision and linkages for referral of complications.
- Linkages between the health system and community groups should be encouraged so that women are informed about the availability of safe services.
- The role of chemists as providers was discussed at length. Since a large number of women access abortion medication directly from chemists, it was felt that services provided by this group need to be studied.
Introduction to the strategic approach: framework for country-level actions on preventing unsafe abortions

Dr Arvind Mathur of the WHO South-East Asia Regional Office introduced this session, which aimed at developing country-specific strategies of action to prevent unsafe abortion. He presented the Strategic Approach Framework to strengthen SRH policies and programmes through a phased approach. This includes identifying and prioritizing needs, generating a broad consensus mandate for action, and introducing and testing interventions – initially on a small scale to address priority needs, and thereafter scaled up to strengthen institutions and spread the benefits to more people. Although the strategic approach was first developed and used to broaden contraceptive choice and improve quality of care in family planning services, its comprehensive nature and flexibility led several countries to adapt and apply it to other specific areas of reproductive health services. In addition to safe abortion, the Approach seeks to assist countries to plan and implement comprehensive packages of interventions and strategies related to STI/RTI, maternal and newborn health and adolescent reproductive health (Annex 15: Strategic approach framework to strengthen sexual and reproductive health policies and programmes).

Following the presentation, participants were divided into groups to develop country plans based on the WHO framework for action on preventing unsafe abortion distributed by Dr Mathur. The groups were asked to reflect on:

- Overall barriers and challenges to access and availability of safe abortion and/or PAC services (regional- and country-specific) within current programmes;
• Experiences from other country technical guidelines and other materials that had been shared;
• The group work, panel discussions, approaches and tools that are available for possible application;
• The field visits, especially with regard to aspects of service delivery, collaboration, private-public partnerships, monitoring and supervision.

The task entailed each country group:
• to develop a plan of action to improve access to, and the quality of safe abortion services;
• to identify steps to adapt, adopt and disseminate the National Guidelines for Safe Abortion;
• to identify the necessary strategic information for prevention and management of unsafe abortion programmes, and how to get the information;
• to identify 3–5 key priority actions at the country level.

(Annex 16: Country Action Plan and group work template for country planning.)

At the plenary, each country presented the priority areas identified in the group and proposed a plan of action to address them. Each had also identified the organizations that would be responsible for implementing the plan of action and the support required to undertake the proposed activities.

**Bangladesh**

• Strengthen government MR and PAC services by expanding the limits for MR/PAC services for providers: for mid-level providers from 8 to 10 weeks and physicians from 10 to 12 weeks;
• Review of MR/PAC training manuals. The steps proposed were to revise the undergraduate teaching materials for health-care professionals, disseminate and adopt the training manual developed by Ipas and approved by the Directorate General of Family Planning (DGFP), and lastly to sensitize professional bodies about the revised and updated guidelines;
• Introduce mifepristone-misoprostol in the national MR programme in collaboration with the drug administration and National Technical Committee;
• Increase community awareness about MR/PAC and family planning services through development and dissemination of existing BCC materials and creation of NGO/ governmental and private partnerships;
• Strengthen and integrate MR/PAC, family planning and antenatal care in government services through advocacy with NGOs and the Government.

These activities would be undertaken by professional bodies like the Obstetrical and Gynaecological Society of Bangladesh; nursing society; Government of Bangladesh including Drug Administration, DGFP; Ministry of Health; Menstrual Regulation with Medication Working Group and NGO partners. To implement activities, support would be needed to acquire required clearances; compile evidence including on feasibility and
acceptability of MR/PAC provision and on introduction of mifepristone-misoprostol for MR.

**Bhutan**

- Enhance clients’ knowledge on safe sex and safe motherhood through innovative IEC and BCC programmes and building the capacity of voluntary health workers to implement this;
- Remove the discrepancies and ambiguity about the existing abortion laws by reviewing and updating them;
- Update existing guidelines on abortion to reflect revised WHO guidelines;
- Train all providers to use the updated WHO guidance;
- Establish adolescent friendly service centres.

These activities would be undertaken by the Ministry of Health with support from donor agencies, legal bodies, NGOs and other departments of the Government.

**Cambodia**

- Increase access to safe abortion in the public sector from the current coverage of 35% to 70%;
- Legalize medical abortion services by mid-level providers;
- Undertake advocacy at the provincial level by working closely with people Health Development, the police, community, judiciary and local authorities;
- Improve post-abortion family planning services by integrating services and ensuring regular supplies;
- Undertake research about knowledge, attitudes of clients and providers; and values clarification.

These activities would be undertaken by service providers, professional bodies and the Ministry of Health, e.g. PSI, MSI, Reproductive Health Association Cambodia, Reproductive and Child Health Alliance, and National Reproductive Health Programme. Support would be required from donor agencies such as AusAid, the European Union, University Research Company and WHO, as well as civil society organizations.

**DPR Korea**

- Expand availability of medical abortion beyond pilot areas;
- Advocate for better access to services, particularly for people living in remote areas and unmarried adolescent girls;
- Expand the abortion provider base to include nurses;
- Disseminate the national guidelines that have been prepared; and adapt them to the updated WHO guidance;
- Strengthen the logistics chain;
• Improve quality of care by providing training, supervision and periodic monitoring;
• Strengthen the role of the National Family Planning Association.

India

• Ensure effective implementation of the MTP Act by empowering District Level Committees, training providers, ensuring regular reporting from public and private sector providers, ensuring regular supply of drugs and equipment, removing restrictive regulations against the spirit of the Act, developing guidelines for services to rape victims and other vulnerable groups, drafting and implementing a national BCC strategy for CAC, taking steps to address barriers due to provider bias and lack of correct information, and finally revising the CAC guidelines in accordance with the updated WHO guidance;
• Move and approve proposed draft recommendations to revision of the MTP Act;
• Promote safe abortion technologies by arriving at a consensus among professional associations, strengthen pre-service training for both MBBS and nursing students, remove D&C and check curettage as a method of service provision, and provide medical abortion updates for existing providers;
• Integrate CAC plan in Programme Implementation Plans (PIP) and ensure implementation by States, and provide technical support and training to state departments for drafting and implementing the CAC component of PIP under the National Rural Health Mission;
• Include non-MBBS providers for PAC and ensure that basic emergency obstetric care guidelines are implemented;
• Arrive at a national and state-level consensus on addressing sex selection and access to CAC through partnership with key stakeholders and a consensus-building exercise, work with the Government to develop policy guidelines on dealing with safe abortion and sex selection in a cohesive manner, and identify champions among media, celebrities and elected representatives to talk about the issue of safe abortion.

These activities would be undertaken through a government-led consortium of partners, NGOs, and stakeholders ranging from policy-makers to elected representatives.

Indonesia

• Conduct a round table for advocacy discussion on the issue of prevention of unsafe abortion to reduce maternal mortality in Indonesia;
• Conduct research to provide evidence for practice and policy;
• Increase accessibility and quality of care for clients with unplanned pregnancies;
• Strengthen reproductive health awareness/education in pre-service and in-service provision;
• Strengthen reproductive health collaboration and networks between the Ministry of Health, WHO, the WHO Collaborating Centre for Family Planning and Reproductive Health, National Family Planning Coordination Board (BKKBN), National Institute of Health Research and Development, United Nations partners,
and developing agencies with a focus on legal and policy aspects to achieve the Millennium Development Goal 5.

These activities would be undertaken by the above bodies along with the Ministry of Education, professional organizations, NGOs working on reproductive health, universities, and community and religious leaders. Support would be required from WHO, BKKBN, the United Nations Population Fund (UNFPA) and the Ministry of Health for different components of the action plan. For example, BKKBN, Ministry of Health, WHO and UNFPA could develop a summary paper on the current situation of abortion in Indonesia, WHO to support a development framework of quality of care for reproductive health including unplanned pregnancy in Indonesia, partners to support the Ministry of Health and collaboration with professional organizations to review and update the reproductive health curriculum for medical and midwifery schools, and WHO in collaboration with BKKBN to conduct a strategic assessment.

**Lao PDR**

- Increase PAC implementation by expanding availability in 50% of all district hospitals and integrate this within the maternal and child health programme;
- Undertake advocacy with policy-makers;
- Review PAC guidelines and undertake pre-service and clinical training;
- Ensure regular monitoring of services and regular supply of drugs and equipment in the district hospitals.

These activities would be undertaken by the Ministry of Health, obstetricians/gynaecologists, WHO, UNFPA and development partners. Support would be required from WHO, UNFPA, NGOs and development partners.

**Maldives**

- Address restricted provision and failure to recognize abortion as legal by authorities by organizing a series of sensitization workshops and an assessment of the country situation;
- Share the feedback from this workshop with colleagues
- Introduce PAC services in the country

These activities would be undertaken by the Ministry of Health and Family Welfare with support from WHO. Technical support would be required to organize the workshops. Support would also be required to ensure regular availability of MVA kits and drugs for medical abortion, and to develop country-specific guidelines, at least for PAC in the initial stages.

**Myanmar**

Provision of PAC services and preventing unsafe abortion by:
- Provision of birth spacing programme down to community level;
Preventing unsafe abortion to reduce maternal mortality

Report of the regional meeting held in Kathmandu, Nepal

- Advocacy for awareness of unsafe abortion and creating awareness about the burden and opportunity for treatment for incomplete abortion;
- Clarification of status of abortion and provision of safe abortion with legal indications;
- Development and dissemination of PAC guideline – including surgical (MVA for doctors) and medical abortion, introducing misoprostol;
- Updating the training module for PAC and training-of-trainers on PAC, with regular follow-up after training;
- Monitoring and evaluation of PAC services and ensuring regular provision of drugs and equipment.

The activities would be undertaken by Maternal and Child Health section of the Department of Health, obstetrics/gynaecology specialists, District/Township Medical Officers, Lady Health Visitors (LHVs) and midwives, Department of Medical Science (preservice training), midwifery schools, NGOs like IPPF, MSI, PSI, Ipas, John Snow Inc., Myanmar Maternal and Child Welfare Association (members and staff of maternity homes and adolescents and community mobilizers) and voluntary health workers. This would require financial and technical assistance from WHO, UNFPA and international NGOs.

Nepal

- Address low awareness of legality of abortion and place of service by assessing audience-based communication strategy, and developing, piloting and scaling up an audience-based communication strategy;
- Address gender equity and social inclusion and reach the underserved population by assessing the coverage of safe abortion services in the underserved population, identifying barriers to access, and piloting and scaling up interventions to increase access to safe abortion services in two remote districts;
- Undertake a strategic assessment of harm reduction (supply and demand dynamics), and develop, pilot and scale up a Harm Reduction Strategy;
- Address low uptake of post-abortion contraception by integrating safe abortion services and long-term family planning services (training, logistics, supervision, monitoring, IEC, service delivery);
- Address the unregulated private sector by developing a private sector strategy for safe abortion services, piloting and scaling up safe abortion services for staff nurses and ANM as per the strategy;
- Provide health financing for safe abortion service by including this in the Ama Surakya Programme (Safe Maternal Incentive Scheme).

These tasks would be undertaken by the Family Health Division of the Ministry of Health. Support would be required from the National Health Training Centre and partners.

Pakistan

- Address the lack of abortion policy by developing provincial standards and guidelines as per the revised WHO guidelines (Punjab), advocate for inclusion of MVA and
misoprostol in Essential Drug and Equipment Lists, engage the Pakistan Medical and Dental College and Pakistan Nursing Council to review and revise curricula to incorporate safe PAC into pre-service training;

- Ensure service delivery by developing standardized PAC training and reference manuals for various cadres (pre- and in-service training modules), and establishing provincial centres for clinical certification of public and private sector providers;
- Advocacy and communication activities to provide an enabling environment and develop a strategic communication framework for multiple audiences.

These activities would be undertaken by the Pakistan Alliance for Postabortion Care and the Department of Health-Punjab in partnership with Ipas and in collaboration with multiple stakeholders. Support would be required from WHO for technical review and feedback to the Department of Health and additional support from the United Nations and development partners.

**Sri Lanka**

- Advocate and lobby for expansion of the number of legal indications for abortion (incest, rape and severe fetal abnormalities);
- Finalize and print PAC guidelines;
- Overcome the shortage of trained personnel and train institutional and field staff in a phased manner;
- Address unavailability of drugs and MVA for PAC, advocate for registration of misoprostol for postpartum haemorrhage and management of incomplete abortion, and establish use of MVA for PAC;
- Reduce relatively high unmet need among special groups like adolescents, widows by strengthening comprehensive sexuality education in schools and family planning services with all methods (including post-placental IUD);
- Increase information on abortion statistics by strengthening existing management information systems to improve reporting and conduct routine national surveys to get accurate information.

These activities would be undertaken by the Government (Ministry of Child Development and Women’s Empowerment), Sri Lanka College of Obstetricians and Gynaecologists (SLCOG), Ministry of Health, Ministry of Education, Registrar General Department of Census and Statistics and research groups. Technical support would be needed, e.g. from SLCOG, WHO, UNFPA, Family Planning Association, and MSI. Funding sources would need to be identified from development partners and NGOs.

**Thailand**

- Advocate for medical abortion drugs registration and address issues related to laws/regulations and the right to safe abortion;
- Provide training and education by updating national guidelines for safe abortion, and modify training curricula for pre-service and in-service training for physicians and nurses;
• Assure service provision by setting up service points at trained facilities and ensuring a regular supply of equipment;
• Build and strengthen networks through annual workshops;
• Carry out monitoring, evaluation and secure management information systems through mentoring visits and abortion surveillance.

These activities would be carried out by the Thai Medical Council, Royal Thai College of Obstetricians and Gynaecologists, medical schools, Ministry of Public Health, Women’s Health and Reproductive Rights Foundation of Thailand, NGOs and partners. Support would be required from the Thai Health Promotion Foundation and international NGOs.

Timor-Leste

• Continue integration of PAC services in emergency obstetric care (EmOC) training through refresher training, include CAC in the EmOC training programme, identify training sites, conduct training-of-trainers and trainees, both old and new;
• Develop national guidelines on PAC services in accordance with the revised WHO guidelines after discussions with national policy-makers;
• Improve the health management information system by classifying cases of abortion as per international guidelines;
• Strengthen existing family planning services by following the revised WHO guidelines and convening national level meetings to revise the guidelines;
• Strengthen the monitoring and evaluation system for quality assurance through regular visits by national and state-level teams to ensure quality of care, and developing, testing and implementing a checklist for gathering statistics.

These activities would be done by the Ministry of Health, UNFPA, obstetrics/gynaecology consultants, general practitioners and midwives, national and state policy-makers and other consultants. Support would be drawn from the Ministry of Health, INS, UNFPA, WHO, UNICEF and international NGOs.
Dr Pravin Mishra, Honorary Secretary, Ministry of Health and Population, Government of Nepal and Dr Frank Paulin, Acting WHO Representative to Nepal attended the country presentations and the closing session. Dr Mishra said that the abortion provider base could be increased by adding six months of obstetrics/gynaecology training to the five and half years’ of medical education. This would ensure quality service delivery at the grassroots level. The other issues that need to be addressed are decision-making, early pregnancy detection and timely access to abortion services. To this end, he proposed BCC activities and community-driven programmes to change people’s attitudes because unless this is done, maternal mortality due to unsafe abortion would continue. Nepal is a hilly country with a scattered population which makes it a challenge to reach those living in these areas. Mechanisms and community-based innovative strategies on how best to reach out to these people need to be developed. Abortion service delivery is multifaceted as it includes stakeholders at different levels – health, community, religion, society, political leaders. There is a need for ongoing support and partnership with NGOs, particularly in training providers.

Dr Mathur thanked the participants for their contributions. He urged them to review and refine their country plans on their return to their respective countries and implement the plans of action that they had formulated, offering WHO technical support to achieve this. At the regional level, the follow-up actions listed below were identified:

- Support immediate, medium- and long term activities in the Region and in countries to adapt and implement the updated guidelines; for example a regional multisectoral advocacy meeting for a more conducive legal and sociocultural environment for safe abortion services;
- Identify research needs to develop strategies for further strengthening safe abortion, e.g. ‘task shifting and sharing’ to expand the provider base and decentralized delivery of abortion services;
- Continue collaboration with partners who have participated at the meeting and others in identifying collaborative work to further support priority country-level actions.
Meeting Secretariat: Regional Meeting on Preventing Unsafe Abortion to Reduce Maternal Mortality
Kathmandu, Nepal, 17 - 20 September 2012
Message from Dr Samlee Plianbangchang
Regional Director, WHO South East Asia Region
(read by Dr Lin Aung, WHO Representative to Nepal)

Distinguished participants, dear colleagues, ladies and gentlemen,

I have the honour to present greetings from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, to the distinguished participants of the Regional Meeting on Preventing Unsafe Abortion to Reduce Maternal Mortality. As the Regional Director is unable to be present here today, I have the privilege of reading out his address on this occasion.

Quote
The need to improve maternal health is identified as one of the key Millennium Development Goals, with a target of reducing levels of maternal mortality by three-quarters between 1990 and 2015. As we all know, achieving this target requires actions on several fronts. Women die because complications during pregnancy, childbirth and the postpartum period go unrecognized or are inadequately managed.

One of important causes of maternal deaths is complications arising as a result of unsafe abortion. Among the 208 million women estimated to become pregnant each year worldwide, 59% (or 123 million) experience a planned (or intended) pregnancy leading to a birth or miscarriage or a stillbirth. The remaining 41% (or 85 million) of pregnancies are unintended.

One of the main reasons for unwanted pregnancies is the lack of knowledge and limited access to family planning services. Although impressive gains in contraceptive use have resulted in reducing the number of unintended pregnancies, this has not eliminated the need for access to safe abortion. No contraceptive method is one hundred percent effective and contraceptive failure is known to occur. An estimated 33 million contraceptive users worldwide are expected to experience accidental pregnancy annually while using contraception. While some of the accidental or unintended pregnancies end up as unwanted livebirths, some are terminated by induced abortions, many of which by unsafe methods.

Women die because they seek to end unwanted pregnancies but lack access to appropriate and safe abortion services. An estimated 22 million abortions continue to be performed unsafely each year of which Asia accounts for 10.8 million.

Globally, this results in the death of an estimated 47 000 women (13% of pregnancy related deaths) and disabilities for an additional 5 million women. This accounts for 20% of total mortality and disability burden due to pregnancy and childbirth.
It is also alarming to note that a large proportion of all unsafe abortions are performed on young women aged 15 to 24. Teenage pregnancy is also a problem in many countries of South-East Asia. Many victims of rape and sexual abuse get pregnant but do not have access to safe abortion services, and suffer the consequences of an unsafe abortion.

Unsafe abortions are associated with serious health consequences, including about 20–30% cause reproductive tract infections and about 20–40% of these result in infection of the upper genital tract. One in four women who undergo unsafe abortion is likely to develop temporary or lifelong disability requiring medical care. Evidence shows that major physiological, financial and emotional costs are incurred by women who undergo unsafe abortion.

For every woman seeking post-abortion care at a hospital, there are several who have had an unsafe abortion but who do not seek medical care, because they consider the complications as not serious, or because they may not have the required financial means, or because they fear abuse, ill-treatment or legal reprisal.

All this can be prevented. There are technologies to prevent such situations. We should therefore focus our efforts more on preventing unwanted pregnancies. Over the past two decades, evidence has been generated and technologies developed for providing safe, comprehensive abortion care. The human rights imperative has made the call stronger for making safe abortion services accessible to women who need it.

Ladies and gentlemen,

At the Special Session of the United Nations General Assembly in June 1999, Member States agreed that “in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible”.

In countries where abortion is legally restricted, post-abortion care services should be made available to those who need it so that maternal death due to complications of abortion can be reduced significantly.

In almost all countries, the law permits abortion to save the woman’s life, and in the majority of countries abortion is allowed to preserve the physical and/or mental health of the woman. Safe abortion services, as provided by law, therefore need to be available.

Where legislation allows abortion under broad indications, the incidence of and complications from unsafe abortion are generally lower than where abortion is legally restricted.

The number of declarations and resolutions signed by countries over the past two decades indicates a growing consensus that unsafe abortion is an important cause of maternal death that can, and should, be prevented through the promotion of family planning, sexuality education, and the provision of safe abortion services to the full extent of the law.
The consensus also exists that post-abortion care should be provided in all cases and that expanding access to family planning is critical to the prevention of unplanned pregnancy and unsafe abortion. Thus, the public health rationale for preventing unsafe abortion is clear and unambiguous.

As a preventable cause of maternal mortality and morbidity, unsafe abortion must be dealt with as part of the Millennium Development Goal on improving maternal health and other international development goals and targets.

All of these deserve continuous and integrated implementation in countries.

The role of the World Health Organization is to develop norms and standards and assist Member States in strengthening the capacity of health systems. I am hopeful that with the updated evidence-based technical and policy guidance to be presented at the meeting, Member States would be able to develop or adapt national strategies for improving women’s reproductive health and reducing unsafe abortion.

Ladies and gentlemen,

I am happy to note that government officials from all South-East Asia Region countries and some countries from Western Pacific and East Mediterranean regions, experts and representatives from institutions, professional organizations, advocacy groups and international NGOs, especially Ipas, Population Services International, Marie Stopes International, the International Planned Parenthood Federation and others working in the area of maternal and reproductive health, as well as representatives from other UN, bilateral agencies, development partners and WHO country offices are participating in this meeting.

My sincere gratitude to our colleagues from headquarters for their continuous support and I would like to thank them for their collaborative work in this area and contribution to this meeting.

Last but not the least, I would like to thank Government of Nepal for hosting the meeting and the WHO Representative Nepal and his staff for their support and cooperation.

Unquote
I shall, of course, apprise the Regional Director of the deliberations of this meeting and its outcome. I wish you a fruitful meeting and a pleasant stay in Kathmandu and look forward to our continued concerted action and collaboration.
Preventing unsafe abortion to reduce maternal mortality

Report of the regional meeting held in Kathmandu, Nepal
Country Presentation - Bangladesh

**Total Population**: 149 million  
(Bangladesh Population and Housing Census 2011, BBS)

**Women of Reproductive Age**: 45.3 million / 30 million  
(UNFPA State of World’s Midwifery 2011)

**Annual no. of Abortion cases**: 900,000 (estimated)  
270,000 (reported)

**Maternal Mortality Ratio**  
in 2010: 194/100,000 live birth (BMMS 2012)  
in 2001: 322/100,000 live birth (BMMS 2001)

---

**General Information**

Maternal Mortality attributed to Unsafe abortion:  
In 2011 : 1% (BMMS 2010)  
In 2001 : 5% (BMMS 2001)

Contraceptive Prevalence Rate:  
In 2011 : 61.2 (BDHS 2011)  
In 1999 -2000 : 53.8 (BDHS )

**Abortion Rate**: 28/1000 WRA

---

**Legal and Policy Status for Abortion:**

- The Penal code (Section 312-316) permits abortion only for the purpose of saving a woman’s life. Abortion is not legal in Bangladesh.
- Abortion can be done where the life of woman is threaten due to continuation of pregnancy.
- There exist penalty clauses for illegal Abortion.
- Informed consent is a must for conducting Abortion on medical ground.

**The Bangladesh Context of Menstrual Regulation**

- MR: Uterine Evacuation without laboratory or ultrasound confirmation of pregnancy for women who report recent delayed menses.
In 1970s GOB declared menstrual regulation (MR) and “interim method for establishing non-pregnancy"

- MR up to 8 weeks LMP using MVA performed by female paramedics (Family Welfare Visitors)
- MR up to 10 weeks LMP performed by doctors
- Decentralized MR has helped reduce MMR in Bangladesh
- Despite decentralized MR, unsafe abortion persists

The Bangladesh Context on PAC

- PAC performed by doctors using D&C in hospitals
- PAC patients rarely linked to contraceptive services
- MR and PAC patients seen in different facilities managed by different directorates of MOH&FW
- MA for MR (MRM) not approved in Bangladesh. Study going on MRM.

Menstrual Regulation (MR) is defined as intended regulation of menstruation of a woman of reproductive age when she developed amenorrhea.??

MR Service Delivery Facilities

Government:

- Medical College Hospitals (8)
- District Hospitals (59), MCWCs (70)
- Upazilla Health Complex -Sadar/MCH Clinic (417)
- UH&FWCs (3725)
- NGOs: RHSTEP, Marie Stopes, FPAB, BAPSA

Private Clinics

MR Service Delivery

- BMDC Registered Doctors who have two weeks basic training on MR can perform MR in between 6-10 weeks of amenorrhea
- Paramedics who have minimum 18 months basic training on FP-RH and also have three weeks basic training on MR can perform MR in between 6-8 weeks of amenorrhea
- MR trained service providers:
  - Doctor 9,864
  - Paramedic 7,702

Available National Standard and Guideline

Recently Ipas Bangladesh developed (2012): approved by government
- Woman Centered MR and PAC Services – Trainer’s Manual
- Woman Centered MR and PAC Services – Midlevel Providers

**MR Service Delivery: Supply**
- DGFP procure MVA kits and distribute to all its service centers.
- Under HPNSDP provision for procurement of 10,000 MVA Kit are kept

**MR Performance 2010**
- MIS reported cases: 245,522
- Estimated cases: 900,000
  (Status includes all GO & NGO service delivery points)

**Program Strength**
- GOB service facility extends up to Union level (Population 25,000; Average Eligible couple 3,000)
- GOB MR service is free of cost
- MR trained service providers are at every GOB facility
- Strong GO-NGO collaboration

**Program Weakness**
- No Community awareness activity
- Poor Monitoring and Supervision
- PAC services are not readily available
- Under reporting of MR services
- Post MR Contraception service is poor

**Issues to be addressed**
- Revisit the existing Abortion policy
- Ensure strategic approaches for effective coordination and cooperation with GOB, NGOs and Private sectors
- Implement effective community awareness program
- Linkage with other RH program activities (Contraceptives, ECP)
- Strengthen PAC services in all Facilities
- Integration of Services for MR, PAC and FP.
Country Presentation - Bhutan

Population = 6,34,982 (2005)
Growth rate = 1.3 (2005)
TFR = 2.6 (2005)
Women of reproductive age group = 157,872 (2005)
Life expectancy = 66 (2005)
Literacy rate = 59.5% (2005)
Health coverage = 90% (2011)

Sources: Annual Health Bulletin 2011

Health Care Delivery System

Trend in MMR

Sources: NHS 1984, 1994, 2000, BMIS 2010
Legal and Policy Status for abortion

1. National Standard on Medical Termination of Pregnancy
2. Penal Code of Bhutan

1. **Provisions of National Standard on Medical Termination of Pregnancy**

   **MTP Definition**
   
   MTP refers to deliberate induction of abortion to save the women from the risk of underlying disease and death, or when the foetus has been shown to have structural abnormalities that predispose to serious handicaps.

   **Major considerations**
   
   MTP will be accepted in Bhutan provided 2 medical doctors recognize to practise under following conditions:
   
   - Continuance of pregnancy carries risk to the mother
   - Gestational age not exceeding 20 weeks and continuing pregnancy predisposes to injury to physical or mental health
   - Substantial risk to child to born with serious handicaps or congenial or physical or mental abnormalities
   - Exception: In cases of emergency (severe heart diseases and cancers), only 1 doctor may give consent

   **MTP by Whom & Where**

   **Whom:**
   
   Any medical doctor recognized by MoH with training in obstetrics and gynaecology or with certificate of required expertise by a competent institution

   **Where:**
   
   Only in government hospitals in the country
   
   Confidentially between doctor and client need to be maintained
Maternal Diseases:
- Severe heart diseases/valve replaced
- Severe Malignant hypertension not responding to treatment
- Malignant tumours- breast or cervix cancers
- Severe renal diseases
- Severe Mental illness

Contraceptive Failure in Pregnancy
- During genuine contraceptive failure

Eugenic
- Risk of serious handicaps to the unborn baby due to physical and mental abnormalities

Procedures

1st Trimester (6-12 weeks)
- Suction evacuation (Menstrual Regulation)
- Dilation & Curettage (D&C)

Mid Trimester Pregnancy
- Vaginal prostaglandin with or without oxytocin infusion
- Abdominal hysterotomy

Source: 3rd Edition of National Medical Standard for Contraceptive Services

2. Provisions of Penal Code of Bhutan

Section 146: "A defendant shall be guilty of the offences of illegal abortion, if the defendant unlawfully aborts or induces expulsion of an embryo or foetus or prevent a child from being born alive, except the act is caused in good faith for the purpose of saving the life of the mother or when the pregnancy is a result of rape or incest, or when the mother is of unsound mental condition"

Section 147: The offence of illegal abortion shall be misdemeanour

Data collection, monitoring and reporting for abortion services
- Health Information and Management System
- Maternal and Neonatal Death Review Reports

Successes in Reducing Unsafe Abortions
- Development of Standard Guidelines on Management of complications of abortion
- Introduction of Emergency Conception
- High level advocacy
- Unwavering commitment from the government and donor agency for family planning services
- Universal access to family planning services through primary health care approach
- Institution of Maternal and Neonatal Death Investigation
Challenges in Reducing Unsafe Abortions

- Socio-cultural factors
- Low knowledge and health seeking behavior
- High youth population
- Difficult geographical terrain
- Shortage skilled manpower
- Difficulty in obtaining data
Annex 2.1

Country Presentation - Indonesia

Socio Economic Condition

- Pop. Growth: 1.49% (2010)
- Rural Population: 57.7% (2000)
- Life expectancy: 71.33 years (2008)
- Ethnic groups: 300
- Income per capita: 3.015 U$D (2008)*
- Poor people: 36 million (2004)
- Literacy rate: 89.5% (2000)
  - Men: 93.5%
  - Women: 85.7%
- Women Reproductive Age (WRA): 65,207,080
- Married Women Reproductive Age: 46,949,096

Health Infrastructure

- Number of:
  - Hospitals: 1,632
  - Community Health Centers: 9,005
  - Integrated service posts: 266,827
  - Village Health Posts: 51,996

- Number of Health Personnel
  - General Practitioners: 25,333
  - Specialist doctors: 7,593
  - ObGyn’s: 2,329
  - Pediatrician: 2,107
  - Nurse: 160,074
  - Midwives: 96,551

*Source: Indonesia’s Health Profile, 2010

- **Old Age (>60 yrs)**: Infrastructure and facilities for the elderly, social security, and nursing homes (panti Jompo)
- **Productive Age (15-60 yrs)**: Facilities and infrastructure in secondary and tertiary education, and the provision of employment
- **Young Age (<15 yrs)**: Social and economic investment in infrastructure and the provision of education and health facilities
General Condition, Problems and Challenges

Total fertility rate (TFR) continued to decline, but during the period 2002/03 to 2007 TFR stagnant. It is caused by an increase in CPR (Contraceptive Prevalence Rate) are not significant and growing unmet need. This resulted in increase in the population growth rate in the period 2000-2010.
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

MDG 5 - TARGET 5A: Reduce 3/4 MMR 1990 - 2015

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>Baseline</th>
<th>Current</th>
<th>Target (2015)</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1. Maternal Mortality Ratio (MMR) 100 000 Live birth:</td>
<td>390 (IDHS 1991)</td>
<td>228 (IDHS 2007)</td>
<td>102</td>
<td>More effort needed</td>
</tr>
<tr>
<td>5.2. Proportion of births assisted by skilled health attendant:</td>
<td>40.70% (Susenas 1992)</td>
<td>82.2% (BHR 2010)</td>
<td>90%</td>
<td>On track</td>
</tr>
</tbody>
</table>

TARGET 5B: Universal Access to Reproductive Health 2015

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>Baseline</th>
<th>Current</th>
<th>Target (2015)</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.3. Contraceptive prevalence rate (CPR) modern method:</td>
<td>47.10% (1991)</td>
<td>57.4% (2007)</td>
<td>65%</td>
<td>Need more attention</td>
</tr>
<tr>
<td>5.5. Antenatal care coverage: 1 visit 4 visits</td>
<td>75% (1991)</td>
<td>92.7% (2010)</td>
<td>95%</td>
<td>On track</td>
</tr>
<tr>
<td>5.6. Unmet need for family planning:</td>
<td>12.70% (1991)</td>
<td>9.1% (2007)</td>
<td>5%</td>
<td>Need more attention</td>
</tr>
</tbody>
</table>


MMR Prediction in 2015 based on IDHS

Indirect cause 45%:
- Infection: Malaria, TB, Hepatitis
- Cardiovascular, Decomp Cordis
- Hypertension, Diabetes Mellitus
- Epilepsy

Source: HHS 2001
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

Antenatal Care 1st & 4th Visit
- 1st Visit: 92.7%
- 4th Visit: 61.4%

Source: BHS 2010

Trend of Delivery by Skilled Birth Attendant, 1990-2010
- 1990: 49.7%
- 2000: 66.9%
- 2007: 75.4%
- 2010: 82.3%

Source: 1990-2007 (National Socio-economic Survey), 2010 (Basic Health Research)

How is the percentage of miscarriage and abortion among WORA from the basic health survey 2010 in Indonesia?
- Miscarriage: 4.0%
- Abortion: 3.5%

Source: Basic Health Survey, 2010

How about methods to end pregnancy?
- Jamu: 39.0%
- Pil: 39.7%
- Tin: 16.3%
- Kunt: 11.9%
- Lainnya: 2.4%

Source: Basic Health Survey, 2010

Who is assisted?
- Miscarriage
  - Dokter: 55.0%
  - Bidan: 20.9%
  - Dukun: 8.9%
  - Sendiri: 13.4%
  - Lainnya: 1.7%

- Abortion
  - Dokter: 12.2%
  - Bidan: 20.6%
  - Dukun: 11.6%
  - Sendiri: 49.4%
  - Lainnya: 6.1%

Source: BHS 2010
Legal and Policy Status for abortion

Abortion is not legal in Indonesia. However, Abortion is stated in the Health Law # 36 Article 75, 76, 77.

Article 75
1. Every person shall be prohibited to commit abortion.
2. Prohibition as referred to in paragraph (1) can be exempted on the basis of:
   a. Indications of medical emergencies detected from the early age of pregnancy, both threatening the life of the mother and/or infant, suffering from severe genetic diseases and/or congenital defects, or which cannot be repaired so as to make the infant difficult to live outside the womb; or
   b. Pregnancy due to rape which can bring about psychological trauma for the rape victims;
3. The actions as referred to in paragraph (2) can only be undertaken after through pre-action counseling and/or mentoring and concluded with post-action counseling carried out by competent and authorized counselors.
4. Further provisions on the indications of medical emergencies and rape as referred to in paragraph (2) and paragraph (3) shall be governed by Government Regulations.

Article 76
Abortion as referred to in Article 75 can only be performed:
1. Before pregnancy attains the age of 6 (six) weeks counted from the first day of the last menstruation, except in the case of medical emergencies;
2. By health workers who have skills and authority with a certificate stipulated by Minister;
3. With the consent from the pregnant mother concerned;
4. With the permission from the husband, except rape victims; and
5. Health service providers satisfying the requirements stipulated by Minister.

Article 77
The Government shall protect and prevent women from committing abortion as referred to in Article 75 paragraph (2) and paragraph (3) which is not qualified, safe and accountable as well as contradictory with religious norms and laws and legislations.

Who can legally provide abortion?
By Health Law it is provided by health workers who have skills and authority with a certificate stipulated by Minister.

Government regulation on reproductive health as implementation guideline for the health law stated criteria for safe abortion, qualified and responsible as referred to in paragraph (1) include:
- performed by a physician or a specialist in obstetrics and gynaecology in accordance with professional standards, service standards and standard operating procedures;
- performed in health care facilities that meet the requirements set by the Minister;
- upon request or consent of pregnant women;
- with her husband’s approval;
• non-discriminatory, and
• not prioritizing the incentives or rewards

Are there any penalties for illegal abortion services for those who provide the services or women who seek these services?
• Those who give drugs to women, and she knows or should know that the drug can cause an abortion, punishable by imprisonment of not more than four and a half years.
• If the act resulted in death of woman, the person sentenced to imprisonment of not more than 6 years.
• If the action was taken without the consent of women, the person sentenced to imprisonment of not more than 12 years.
• If the action was taken without the consent of women, and also resulted in the death of the woman, the person liable to imprisonment of not more than 15 years.
• The measures mentioned above are not subject to penalty, if the drug was administered by a doctor in a hospital or clinic where such action is warranted by the rules of abortion.

Delivery of Abortion Services

What are the training requirements to become a certified provider of abortion services?
• Performed by a physician or a specialist in obstetrics and gynaecology in accordance with professional standards, service standards and standard operating procedures;
• The doctor shall be trained by an accredited training providers.

Where can abortion be provided legally?
• It can be performed in a selected approved health-care facility that fulfilled the Ministry of Health standards.

Is post abortion family planning services offered or available?
• No

Data collection, monitoring and reporting for abortion services
• No routine data, only by survey

Successes and Challenges in Reducing Unsafe Abortions

Successes in reducing unsafe abortions:
• Government regulations on reproductive health as implementation guideline for the health law # 36 is in process
• Free delivery financing scheme Program (“Jampersal”)

Challenges in reducing unsafe abortions:
• Socio cultural factors
• Difficulty in collecting data related to abortion, because of the legal status → OR on abortion highly needed
Preventing unsafe abortion to reduce maternal mortality

Report of the regional meeting held in Kathmandu, Nepal
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

Annex 2.2

Country Presentation - India

Total Population: 1.2 Billion
Number of states, UTs: 35
Population of Largest state (UP): 200 Million
Number of birth per annum: 27 Million

Trends in Maternal Mortality Ratio
- Two states: Kerala and Tamil Nadu have achieved the MMR goal, while Maharashtra is close.
- Four states are within striking distance.

MMR Across States
- Annual Rate of Decline between 2004/06 and 2007/09 is 23% higher than Annual Rate of Decline between 1999/2001 and 2004/06.
- Wide disparities between states
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

Maternal Deaths... Unacceptable numbers

- About 30 million pregnancies per year in India.
- 27 million live-births
- 56,000 maternal deaths per year
- 4500 deaths due to abortions.

Causes - Source: RGI-SRS 2001-03

NRHM - Releases & Expenditure 2005-06 to 2011-12

Releases have increased from 800 million US $ to 3.3 billion US $ in 7 years

Key Challenges

1. Utilizing fully the NRHM funding for 2012-13
2. Doing it Well……i.e. More Health for Money !!
3. Getting prepared to absorb the enhanced funding from next year onward

Maternal Health Strategies

- Demand Promotion - Janani Suraksha Yojana
- MULTI-PRUNGED APPROACH.

Prevision of Services: Private sector

- Accreditation of Pvt. Health Facilities for RCH services and SSA training
- Fixed package for outsourcing services

Prevision of Services: Public sector

1. Essential and Emergency Obstetric Care
   - Quality ANC, INC, Safe and Institutional delivery
   - Skilled birth attendance
   - Multi-siding –LSAS, EmOC
   - Operationalize FRUs & 2x4*7 PHCs
2. Services for RTIs & STIs – convergence with the NACP
3. Safe abortion services - New Guidelines
4. Strengthen referral systems
   - Village Health and Nutrition Day… Mother-Child Protection Card

- Maternal Death Review
- Janani Shishu Suraksha Karyakram (JSSK)
- Mother and Child Tracking –web enabled system
- Prioritizing resources for identified “delivery points” or MCH Centers
- Strengthening of IEC/BCI to develop a comprehensive package for IPC, mid media and mass media.
- Constitution of QACs.
Estimates on Abortions... the Indian scenario

- 11 million abortions per year
- 6.7 million induced abortions
- 2/3rd are estimated as unsafe
- 8% of maternal deaths per year !!!

Mere estimates... Numbers could be many more

Estimates ...varying
Where do we stand?

Abortion as a Survey Indicator

Abortion as an outcome of Pregnancy (AHS Vs DLHS-3)

Pregnancy to Women aged 15-49 years resulting in abortion (%), (AHS 2010-11)

Abortions in Institutions (%), (AHS 2010-11)
**International Estimates…**


Estimates for South Central Asia Region - India, Afghanistan, Bangladesh, Bhutan, Iran (Islamic Republic of), Kazakhstan, Kyrgyzstan, Maldives, Nepal, Pakistan, Sri Lanka, Tajikistan, Turkmenistan, Uzbekistan.

- **Unsafe abortions constitute 65% of the total abortions in the South Central Asia Sub region.**
- **India specific comments:** “Abortion is legally permitted and available under broad conditions but many abortions nevertheless take place outside of health services legally authorized to conduct abortions; some of these are deemed safe and some unsafe.”

The MTP Act (Act No. 34 of 1971)

*‘An Act to provide for the termination of certain pregnancies by registered medical practitioners & for matters connected therewith & incidental thereto.’*

- Legislated by Parliament on August 10, 1971
- Act enforced nationwide from April 1, 1972
- Adopted by Jammu & Kashmir & Mizoram in 1980

MTP Act 1971…a landmark legislation

**Objectives**

- Define situations & circumstances in which safe abortion can be legally performed.
- Empowers medical practitioners & institutions delivering these services.

**What does the MTP Act Cover?**

- Gestation limits for MTP
- Indications for MTP
- Who can provide MTP
- Where can MTPs be provided
- Who can give Consent
- Penalties for violation of the Act

**Amended MTP Act 2002**

- **Decentralization** of power for approval of MTP Centers, from the State to District level – formation of empowered District level Committees (enlarge the network of Safe MTP providers).
- Specific **punitive measures** for performing MTPs by unqualified persons and in places not approved by the Govt. or empowered Committee.
- **Bifurcation of facility requirements** - 1st and 2nd trimester MTPs
- Recognition of **Medical Methods of Abortion**
Further Amendments Proposed …

- Amended Preamble to Broaden Scope
- Adding New Definitions to Introduce Clarity
- Redefining Guardian to Rationalize Individual Autonomy
- Rephrasing Terminology to Broaden Service Providers’ Base
- Inclusion of New Categories of Service Providers
- Rights Based Access to Early Abortion
- Refocusing Indications for Second Trimester Abortions
- Rationalizing Punishment under the MTP Act
- Late Term Abortions

Safe Abortion Services.. Policy and Programme Framework

- Recognizing the need for increasing access to safe abortion, the National Population Policy 2000 had laid down operational strategies in its Action Plan for Safe Abortion Services.

Reproductive and Child Health Programme – Phase I: 1997-2005

- Actions initiated for improving MTP facilities and their utilization, and to make SAS accessible to women (particularly rural areas)
- Assistance was provided for skill-based training to doctors and supply of MTP equipment.
- Guidelines for MTP up to 8 wks, using MVA (2001) to enable PHC MOs to provide safe abortion services.
- Guidelines for the use of RU-486 (Mifepristone) with Misoprostol by MOs to ensure safe medical abortion in early pregnancy (WHO-CCR)

RCH-II NPIP framework..2005

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<th>Strategies for promoting safe MTP:</th>
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<tbody>
<tr>
<td><strong>Provide comprehensive and high quality MTP services at all FRUs</strong></td>
</tr>
<tr>
<td><strong>Train Medical officers in safe MTP techniques.</strong></td>
</tr>
<tr>
<td><strong>Provide MVA (Manual Vacuum Aspiration) facilities at all CHCs and at 24 x 7 PHCs.</strong></td>
</tr>
<tr>
<td><strong>Promote use of medical abortion at Govt. and private institutions in early pregnancy; dissemination of guidelines for the use of RU-486 (Mifepristone) with Misoprostol.</strong></td>
</tr>
<tr>
<td><strong>Train ANMs, ASHAs and other field functionaries to provide confidential counselling for MTP and promote post-abortion care through these workers.</strong></td>
</tr>
<tr>
<td><strong>Encourage private and NGO sectors to establish quality MTP services.</strong></td>
</tr>
</tbody>
</table>
Key Milestones

- Approval of Mifepristone by the Drug Controller General of India in 2002
- Misoprostol approved for ob-gyn indication including use for early abortion in combination with Mifepristone in 2006
- Amended MTP Act/ Rules (2002-03) recognized Medical Abortion :
  - MA/ MMA approved for termination of pregnancy up to 7 weeks:
    - Section 5 of the MTP Rules allows the use of RU - 486 (Mifepristone) and Misoprostol for termination of early pregnancy up to seven weeks (49 days) under certain specified conditions by a registered provider
  - Only an RMP (as per MTP Act) can prescribe the drugs
  - Can prescribe in his/her clinic (even if unapproved site), provided he/she has access to an approved site - should display a certificate from owner of approved site

Policy to implementation… Challenges

- MVA guidelines-GOI (2001)

Till recent years, no attempts to introduce MMA in public sector facilities!
Health facilities lacked infrastructure, trained providers, drugs, backup to manage complications

Comprehensive Abortion Care Guidelines

The document is aimed at transforming abortion services from being just a ‘clinical procedure’ to ‘Woman centered Comprehensive Abortion Care’ which includes the following:

- Empathetic counseling
- Proper screening
- Use of safe & updated technologies
- Appropriate infection control measures
- Contraceptive services & post abortion care
- Referral linkages

Operationalizing Trainings

Roll out of MTP/CAC trainings at State & District level (broad steps)
New Initiatives..

- **Directives issued to the states** in September 2011 for implementation of action points on CAC services alongwith a six monthly monitoring format:
  - Inclusion of MA drugs in the EDL.
  - Procurement/supply of MA drugs to make them available in public sector facilities with trained providers.
  - Strengthening Dist. Level Committees for certification of Pvt. sector.
  - Reminders in December 2011 and May 2012.

- **State Plan Appraisals**: One page format (Annexure-X) for getting information from states before Plan Appraisals.

- Series of State level CAC Workshops (5) to orient state/district level officials:
  - MP
  - Chhattisgarh
  - J&K
    - Jammu Division
    - Kashmir Division
  - Rajasthan

More State level workshops have been proposed.

- **Post workshop follow-up** with the State MDs at DC/JS level to indicate the way forward.

- Facilitation of States to include activities for strengthening of CAC Services in the PIP 2012-13 and allocation of funds under NRHM.

- Strengthening strategies for IEC/BCC on safe abortion:
  - Prototype of print IEC material has been developed and being shared with states
  - Poster
  - Flipbook
  - ASHA/ANM Booklet
  - Leaflet

- Communication strategy for A-V Mass Media being planned.
**Roadmap for states for 2012-13**

All District Hospitals and other similar district level facilities (e.g District women and children hospital) to provide the following services:

- 24*7 service delivery for CS and other Emergency Obstetric Care.
- 1st and 2nd trimester abortion services.
- Conduct Facility based MDR.
- Essential newborn care and facility based care for sick newborns.
- Family planning and adolescent friendly health services
- RTI/STI services.
- Have functional BSU/BB.

CHCs and other health facilities at sub district level (above block and below district level) functioning as FRUs to provide the same comprehensive RMNCH Services.

PHCs / Non FRU-CHCs to provide the following services:

- 24*7 BeMOC services including conducting normal delivery and handling common obstetric complications.
- 1st trimester safe abortion services. (MVA upto 8 weeks and MMA upto 7 weeks)
- RTI/STI services.
- Essential newborn care.
- Family planning

**Programme Monitoring Indicators.. through 6-monthly monitoring tool**

- **District level indicators**: On guidelines, DLCs, MMA, MVA.
- **Capacity building**: Training sites, trained manpower, deployment.
- **Service Availability and Service Utilisation**: Services at different levels of facilities:
- **IEC/BCC**: Plan and Mechanisms
- **Supportive supervision**: Mechanisms
- **Bio medical waste management**: Mechanisms

### Status of CAC Training

<table>
<thead>
<tr>
<th></th>
<th>MTP Trained providers -till date</th>
<th>Target 2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>6715</td>
<td>2287</td>
</tr>
</tbody>
</table>

Source: PIP Annexure 2012-13

### Challenges for the states...

**Policy/Planning /Implementation**
- Create awareness and convince policy makers/political leaders
- Clarity on planning for capacity building of service providers, their rational deployment and post training FU for utilization of skills
- Strengthen processes and mechanisms for implementation of MTP Act and monitoring and regulation of private sector providers
- Balance measures to curb declining sex ratio with issues on rights of women to access safe abortion services

**Service Delivery**
- MVA/EVA equipment and drugs to be provided at Health Facilities with trained providers.
- Priority to operationalization of Comprehensive abortion care services in public sector at “Delivery points or branded RMNCH Centres”.
- Strengthening of IEC/BCC Plans

### Abortion and Family Planning...

“Abortion incidence is inversely associated with the level of contraceptive use, especially where fertility rates are holding steady, there being a positive correlation between unmet need for contraception and abortion levels."

#### Family Planning Programme in India...expanding choices

- Emphasis on **Spacing methods** – IUCD
- Emphasis on **minilap tubectomy** services.
- Ensuring quality care in Family Planning services by establishing **Quality Assurance Committees** at state and district levels
- **P-P-P** - Engaging private/NGO organisations for capacity building of FP providers and expanding the provider base

![Current use of Family Planning Methods](Source: DLHS-3 (2007-08), IIPS Mumbai)
● Efforts for increasing male participation and promoting Non scalpel vasectomy (NSV)
● **Compensation scheme for sterilization acceptors**: compensation for loss of wages to the beneficiary and also to the service provider (& team) for conducting sterilisations.
● **National Family Planning Insurance Scheme** (NFPI) : Insurance in the eventuality of death, complication and failure following sterilization and the providers/accredited institutions are indemnified against litigation.
● **Demand generation activities**: Communication Campaigns: print and mass media

**New Interventions to Improve Access to Contraception**

● Delivery of contraceptives at doorstep utilizing the services of ASHA - being implemented in 233 districts of 17 states.
● Cu IUCD 375 - Short term IUCD (5 years)
● Post-partum IUCD introduced - 276 district hospitals in high focus states identified for providing PPIUCD services.
● Promoting Post - partum Family Planning services at district hospitals by deploying dedicated Family Planning Counselors

**Way forward…**

● **Capacity building**... CAC training – strengthening role of SIHFW, Med. Coll., public private partnerships; orientation and training of field functionaries
● Priority on providing full complement of resources for abortion services at identified “delivery points” ... advertisement and branding as RMNCH Centres
● **Inclusion of MA drugs in EDL**, procure and make available at designated facilities
● Comprehensive package for IEC/BCC on CAC services:
  - Mid-media (posters, pamphlets, IPC Booklets)
  - Communication campaign for AV Mass media (radio jingles, TV spots) ..being initiated
● Strengthen role of State Drug Control Authorities for enforcing regulations on sale of MA drugs

**MTP Act 1971…a landmark legislation**

● **AIM**:
  - Reduce maternal mortality and morbidity due to unsafe abortions.
  - Provide safe, affordable, accessible and acceptable abortion services to women who need to terminate an unwanted pregnancy.
● Lays down conditions under which pregnancy can be terminated.
● Places where such terminations can be performed.
● Persons who can terminate a pregnancy.
● Methods to be used in accordance with duration of pregnancy.

**Further Amendments Proposed...**

Process from 2006-2010

● September 2006
  - Expert group of stakeholders constituted by MOHFW GOI
• Options discussed & subcommittee appointed to draw up draft recommendations; Population Council offered to carry out OR on MLPs

• 2007-08
  • Consultations of Sub-Committee on Recommendations

• October 2008
  • Draft Proposal evolved by the Expert Committee

• End 2008-09
  • Repercussions of the Niketa Mehta Case:
    • Successive consultations on the issue of Late term abortions....lack of an absolute consensus...divergent views on how to operationalise the proposed amendment

• 2010-AYUSH providers — include Unani Practitioners

Family Planning Programme in India

• Greater emphasis on Spacing methods like IUCD.
• Availability of Fixed Day Static Services at all facilities.
• Emphasis on minilap tubectomy services.
• Ensuring quality care in Family Planning services by establishing Quality Assurance Committees at state and district levels
• Accreditation of more private/ NGO facilities to increase the provider base for family planning services under PPP.
• Increasing male participation and promoting Non scalpel vasectomy
• Compensation scheme for sterilization acceptors - under the scheme MoHFW provides compensation for loss of wages to the beneficiary and also to the service provider (& team) for conducting sterilisations.
• ‘National Family Planning Insurance Scheme’ (NFPIS) under which clients are insured in the eventualities of deaths, complications and failures following sterilization and the providers/ accredited institutions are indemnified against litigations in those eventualities.
• Demand generation activities in the form of display of posters, billboards and other audio and video materials in the various facilities

New Interventions to Improve Access to Contraception

• A new scheme has been launched to utilize the services of ASHA to deliver contraceptives at the doorstep of beneficiaries. Scheme is being implemented in 233 districts of 17 states. ASHA is charging a nominal amount from beneficiaries for her effort to deliver contraceptives at doorstep i.e. Re 1 for a pack of 3 condoms, Re 1 for a cycle of OCPs and Rs 2 for a pack of one tablet of ECP.
• MoHFW has introduced short term IUCD (5 years effectivity), Cu IUCD 375 under the national Family Planning programme for which capacity building of trainers and service providers is being done.
• A new method of IUCD insertion (post-partum IUCD insertion) has been introduced by the Govt. 276 district hospitals in high focus states have been identified for strengthening PPIUCD services.
• Promoting Post-partum Family Planning services at district hospitals by placing of dedicated Family Planning Counselors and training of personnel.
Annex 2.2

Country Presentation - Nepal

General Information

- Recent population census 2011 indicates that total current population of Nepal is 28.5 million of which 7.5 million are women of reproductive age
- Nepal has been able to reduce maternal mortality by half in last decade
- Abortion remain one of the leading cause of maternal mortality
- Reliable estimate of abortion rate is not available
- Gilda Sedgh et al 2007 reports that abortion rate was 5/1000 women of reproductive age in 2003


<table>
<thead>
<tr>
<th>Causes of maternal death in community (n=132), NMMM Study 1998</th>
<th>Causes of maternal death in community (n=160), NMMM Study 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proper and insufficient care 43%</td>
<td>Haemorrhage 24%</td>
</tr>
<tr>
<td>Puerperal Sepsis 19%</td>
<td>Other Direct 6%</td>
</tr>
<tr>
<td>Eclampsia 12%</td>
<td>Obstructed labour 5%</td>
</tr>
<tr>
<td>Obstructed labour 14%</td>
<td>Abortion 7%</td>
</tr>
<tr>
<td>Other Direct 4%</td>
<td>Puerperal Sepsis 5%</td>
</tr>
<tr>
<td>Abortion 4%</td>
<td>Eclampsia 21%</td>
</tr>
<tr>
<td>All indirect 16%</td>
<td>Obstructed labour 8%</td>
</tr>
</tbody>
</table>
Causes of maternal death in facility 1998 and 2008

Trend of contraceptive use by method type

Legal and Policy Status for abortion

- Abortion was legalized in 2002 in Nepal under following conditions:
  - for any woman up to 12 weeks of pregnancy
  - up to 18 weeks of pregnancy if the pregnancy is the result of rape or incest
  - at any time during the pregnancy if the life, physical or mental health of the woman is at risk or if the fetus is deformed

Consent is required for all women and consent of the guardian is also required for women under 16, the guardian can be any adult
### Implementation Status of safe abortion In nepal

<table>
<thead>
<tr>
<th>Year</th>
<th>Activities</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>• Formation of a Task Force under the leadership of FHD</td>
<td>MoHP Approved</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• SAS procedural order &amp; implementation plan</td>
</tr>
<tr>
<td>2003</td>
<td>• Formation of a sub-committee (TCIC) to implement the two year implementation plan.</td>
<td>• Four working groups (SD, IEC, monitoring, training) produced materials, training plans &amp; QA monitoring checklists</td>
</tr>
<tr>
<td>2004</td>
<td>• Capacity building (trainers’, policy makers, partners)</td>
<td>• Adapted Vietnam’s CAC model in Nepal</td>
</tr>
<tr>
<td></td>
<td>• Exposure on CAC model in Vietnam</td>
<td>• 1st SD from Maternity hospital</td>
</tr>
<tr>
<td>2006</td>
<td>• Piloted nurse training program</td>
<td>• Increased nurse led CAC facilities</td>
</tr>
<tr>
<td></td>
<td>• DDA registered MA drugs</td>
<td>• MA drugs available in 2d tri sites</td>
</tr>
<tr>
<td>2006-to date</td>
<td>• Increasing coverage of MVA, 2nd trim and introduction of MA through public –private-NGOs sites</td>
<td>• Coverage -at least one CAC site in 75 districts</td>
</tr>
</tbody>
</table>

### Implementation status of medical abortion service in Nepal

- MA pilot study 2009 conducted in 6 districts
- MA scale up strategy developed in 2009
- Scale Up Strategy Helped To Expand MA In 75 Districts
- By the end of 2010 MA was introduced in all 75 district hospitals
- MA was limited to hospitals and few PHCs only
- Many rural women were still not able to access safe abortion service

### Current status of medical abortion service

[Map showing MA District Yearwise]
Availability of MA drug

- Co-packed medical abortion drug (misoprostol 800mcg and mifepristone 200mg) available through LMD/DoHS which is supplied to health facilities “free of cost”
- Whereas through social marketing, the cost is fixed at Rs. 318 ($3.5) per co-packed MA drug for public sector and Rs. 363 ($4.03) for private sector
- To date DDA has approved only four types of Co-packed MA drugs Medabon (Sun Pharmaceuticals), MTP Kit (Cipla), Mapriest (Lomos) but unregulated MA drugs due to open border remains a big challenge for ensuring safe MA care

Requirement and process for certification and accreditation of facilities and providers

- Certification process of Providers:
  - Selection and training of eligible participant using standard criteria
  - Evidence of competency
  - Provider listed “safe abortion provider”
- Certification of Sites:
  - Selection of appropriate sites using standard criteria
  - Site strengthening for minimum requirements
  - Site listed as “safe abortion site”

Abortion service providers and sites

<table>
<thead>
<tr>
<th>Year</th>
<th>No of providers trained (June 2011)</th>
<th>No. of sites listed (June 2011)</th>
<th>No. of cases (June 08)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 2004</td>
<td>54</td>
<td>12</td>
<td>719</td>
</tr>
<tr>
<td>2004</td>
<td>95</td>
<td>57</td>
<td>10,561</td>
</tr>
<tr>
<td>2005</td>
<td>111</td>
<td>64</td>
<td>47,451</td>
</tr>
<tr>
<td>2006</td>
<td>114</td>
<td>34</td>
<td>73,474</td>
</tr>
<tr>
<td>2007</td>
<td>138</td>
<td>39</td>
<td>97,378</td>
</tr>
<tr>
<td>2008</td>
<td>192</td>
<td>39</td>
<td>83978</td>
</tr>
<tr>
<td>2009</td>
<td>257</td>
<td>86</td>
<td>88938</td>
</tr>
<tr>
<td>2010</td>
<td>315</td>
<td>156</td>
<td>95306</td>
</tr>
<tr>
<td>2011</td>
<td>359</td>
<td>156</td>
<td>35941</td>
</tr>
<tr>
<td>Total</td>
<td>1276</td>
<td>487</td>
<td>533746</td>
</tr>
</tbody>
</table>
Delivery of abortion services

Availability of national standards, guidelines and training manuals

- Safe Abortion procedural Order -2003
- National Safe Abortion Policy -2004
- CAC Training Manuals -2004
- National RH Clinical Protocol -2008
- MA Training Manuals -2008
- National MA Scale UP Strategy -2009
- Second Trimester Implementation Guidelines -2010
- Safe Abortion Implementation Guidelines -2011

Availability of post abortion care and post abortion family planning

- Post abortion care:
  - PAC service available 24 hour as an EmOC since 2000
- Post abortion family planning:
  - 80% for any type of modern contraceptives and 50% for long term modern contraceptive methods (HMIS)
  - Counseling, commodities supplies and provider’s skills need to strengthen so that women get post abortion contraceptive methods of their choices and as per their RH needs

Data collection monitoring and reporting for abortion services

![Diagram showing data collection monitoring and reporting for abortion services]
Success in reducing unsafe abortion

- Strong government leadership
- Evidenced based policies, strategies, protocols and standard
- Mid level providers led comprehensive abortion care
- Coverage in all 75 district based hospitals
- In 10 years, > 500,000 women served with safe abortion care
- Percentage of abortion complication decreased by almost 50% (41% in 1998 to 26% in 2008) (NMMM study SSMP, 2008)
- MMR fell from 539 per 100000 LB in 1996 to 281 per 100,000 LB in 2006
- MDG Award (September 2010) given to Nepal for progress toward MDG 5 (reducing maternal mortality)

Overcoming future Challenges

- Increasing awareness on the legal provision of abortion (38% NDHS 2011)
- Increasing access to safe abortion care through MA
- Reaching women through FCHVs (Female Community Health Volunteers)
- Educating young women to make reproductive choices
- Educating women on safe provision of MA vs OTC (over the counter)
- Ensuring there is no cost barrier specially for the poor women

Community Based RH leaders - FCHVS
Annex 2.2

Country Presentation - Sri Lanka

Health Related Indicators

- Population 20.3 Million (2012)
- GNP per capita US$ 2040 (2010)
- Population Growth rate – 1.1% (2007)
- Life Expectancy at Birth (2006)
  - Female – 76.4 yrs
  - Male – 71.7 yrs
- Adult Literacy Rate (2006)
  - Male : 92.7 %
  - Female : 89.1 %
- MMR: 31.4/100,000 LB (2009)
- IMR : 8.9/1000 LB (2007)
- Total Fertility rate – 2.3 (2007)
- Contraceptive prevalence rate – 68.4% (2007)

Sri Lanka


Women in the reproductive age group (15-49 yrs)

‘Married’ Women : 3.2 million (15%)
Abortion statistics

- No reliable data source
- May go under reported due to legal issues
- Sources of morbidity data
  - Hospital Indoor morbidity mortality statistics
    - Issue of correct classification of cause of death
  - Public Health statistics thro RH-MIS
    - Tendency to report spontaneous abortions
  - Research studies

Abortion statistics

- Sources of mortality data
  - Vital Statistics thro Dept. of Registrar General
    - In correct classification COD common
  - Hospital Indoor morbidity mortality statistics
    - Quality of reporting with correct COD
  - Maternal Mortality statistics from MD surveillance system
    - Deaths due to Abortions are reported regularly

Research Studies

- National study done in 1999 (Rajapksa L et al)
- Revealed that 650 abortions / day-240,055/year
- Findings:
  - Mostly among rural and semi urban women
  - Married women aged 25-39 yrs
  - Women with 2 or more children
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

National Maternal Mortality Progression
1995-2009

Cause-Specific Maternal Mortality Ratios
(2001 – 2008)

Analysis of cause of Maternal deaths – 2010

Contraceptive Prevalence

Prevalence of modern temporary methods

Family planning service delivery indicators

(Source: DHS 2000, 2006/07)
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

Contraceptive prevalence rate – DHS 2006/7

Legal and Policy Status for abortion

- Sri Lanka abortion laws are very restrictive
- Abortion is criminalized in TOTO under the Penal Code section 303 and 304
  - A woman can access abortion services or abortion can be accessed only to save a woman’s life including Psychotic conditions (suicidal tendencies), Previous History of infanticide with adequate evidence
- Many efforts made to legalise abortion since the 1970’s

Abortion services

- Only Gynaecologists can provide abortion services.
- Legal abortion services for women with clear medical indication to save the life of the woman is available at all specialised gynaecology units of all government hospitals.
- Consent by the patient as in other surgical procedures
These services are free of charge but need to be certified by two obstetricians/gynaecologists and or a Psychiatrist.

The women presented with abortion complications are hospitalised and the treatment is free of charge.

Methods

- No national standards and guidelines for service component
- Menstrual regulation through evacuation is the most preferred method
- The other method used is dilatation & curettage
- Recommended gestational period for abortion has not been specified
- Medical abortions not permitted under the law though practiced by some
- Misoprostol is not a registered drug
- It is freely available in the private sector

Penalty clauses of the law

- Anyone who causes a miscarriage will be imprisoned and/or fined unless the miscarriage is done in good faith to save the life of the woman.
- Punishment varies
  - depending on the gestation age
  - whether the woman has induced her own miscarriage
  - the woman’s consent has been obtained
  - the procedure causing death of the woman

Successes in Abortion and post abortion services

- Primary prevention of abortion
  - Improving availability and accessibility to Family planning services by addressing the unmet need which is streamlined during the last decade
    - Dedicated FP clinics in all hospitals
    - Promote post placental IUCD insertion
    - Establishment of field FP clinics one per 10,000 population
  - Indicators on CPR and unmet need included in the routine RHMIS
- Promoting of emergency contraception in situations where it is indicated with social marketing

Development of Post abortion care guide

- By the technical inputs of SLCOG in collaboration with FHB and UNFPA
- Streamline service delivery, care and further prevention
  - Post abortion services in specialized Gynaecology units
  - By trained staff
■ Provision of family planning services
■ Monitoring and evaluation of service delivery built into HMIS

Revision of Abortion Law

- Advocate to liberalize the abortion law – at policy level Initiated by Ministry of Health, FPA, SLCOG with the leadership of Ministry of Child Development and Women’s Empowerment
- Conditions:
  - Under 16 pregnancies if mother doesn’t want to continue the pregnancy or in the case of incest with the concurrence with parents
  - If the fetus is having a lethal condition or having a condition which lead to very poor quality of life, if diagnosed before 20 weeks.
  - Abortion after 20 weeks are allowed if there is a grave risk to the life of the women or evidence severe fetal abnormality (Diagnosis to be made by 2 specialists from 2 different specialties)

 Conditions in fetus that permit abortion are

- Autosomal recessive chromosomal abnormalities
- Eg: Metabolic disease
- Serological evidence of recent Rubella infection
- Chromosome 13 trisomy syndrome
- Chorioamnionitis
- Achondrogenesis

Challenges on abortion care and post-abortion care

- Social and cultural barriers, Political pressure on liberalization of law
- Whether liberalization will increase the unsafe abortions under legal cover
- Mobilization of funds for establishing abortion and post abortion care services
- Making attitudinal changes among all stakeholders including health care workers
Annex 2.3
Country Presentation - Cambodia

General Information

Population : 14.2 million
Women in : 3.5 million
Reproductive Age

Maternal Mortality Ratio

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>437</td>
<td>472</td>
<td>206</td>
</tr>
</tbody>
</table>

Source : CDHS, 2000, 2005 and 2010

Causes of Maternal Mortality

- Hemorrhage: 35%
- Other Causes: 30%
- Infection: 8%
- Preeclampsia/Eclampsia: 18%
- Abortion: 9%

Source: Cambodia Global Health Initiative strategy, September 2011, USAID/PEPFAR/CDC
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

Availability and Price

- Only 17% of providers trained in CAC (2009)
- Surgical abortion costs $17/ rural and $20-$250 in urban (PSI Research)
- 42.7% of women going to the private sector; 14.1% public, and the rest at home or others. (CDHS 2010)

Knowledge

<table>
<thead>
<tr>
<th>… Among Women</th>
<th>… Among Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 82% of women believe that abortion is illegal</td>
<td>• Only 1 in 5 providers reported having formal training in MA</td>
</tr>
<tr>
<td>• Half of women don’t know where to get an abortion</td>
<td>• Only 17% trained in CAC</td>
</tr>
<tr>
<td></td>
<td>• None could state the correct MA dosage and regimen</td>
</tr>
</tbody>
</table>

Abortion Law

- Abortion legalised in 1997, up to 12 weeks gestation on request for any women is 18 years old or above.
- For women below 18 the permission of a guardian is required.
- For gestation over 12 weeks it is legal under specified circumstances.
- Abortion can only be legally carried out by a health professional (doctor, medical assistant, secondary midwife) who has received the MoH training and has the certificate and authorisation from MoH
- Abortion can only be legally carried out in a hospital, health centre, private clinic or maternity home that has been authorised by MoH
Program Interventions: Public Sector

- Increase access to safe abortion including MA.
- Providing safe abortion training for government health workers
- Upgrading selected public hospitals and health centres as safe abortion service centres
- Ensure linkages to family planning post-abortion services

Program Interventions: Private Sector

- Replace poor quality drugs with high quality, safe, subsidized product who are legally able to provide upon prescription
- Encourage referrals to safe abortion providers through hotline and community education

Delivery of Abortion Services

<table>
<thead>
<tr>
<th>MPA: Health Center</th>
<th>CPA</th>
<th>CPA+</th>
<th>Private Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>management of abortion &lt; 12 weeks</td>
<td>management of safe abortion</td>
<td>management of safe abortion</td>
<td>Follow MoH guideline</td>
</tr>
<tr>
<td>refer the abortion with infection &amp; complication</td>
<td>refer abortion with complication</td>
<td></td>
<td>• blood transfusion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• operation as necessary</td>
</tr>
<tr>
<td>FP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: CDHS 2010
Challenges in Reducing Unsafe Abortions

- 8 in 10 Cambodian women still believe it is illegal (PSI Cambodia research 2010).
- CHALLENGES with ensuring post SA FP.
- Ensuring provider prescription behavior for MA

Public Sector – Results to date

- 74 RHs out of 76 RHs Trained in CAC
- 249 HCs out of around 1,000 HCs trained in BAC.
- Total of 942 staff trained in either BAC or CAC

Programmatic Results

Types of abortion that women ever had 2010 & 2011 WRA TRaC

Early Programmatic Results

1. Overall number of abortions has not increased.
   (CDHS) 7.9 % in 2005 to 5.4% in 2010
2. Unsafe abortion is on the decline:
Annex 2.3

Country Presentation - Maldives

General Information
Country population : MMR / 100,000 Live Births (number of women of reproductive age)
2006 - 69
2011 - 112
Maternal mortality ratio : 2010 - One out of Eight deaths attributed to septic abortion
Proportion of maternal mortality attributed to unsafe abortion : 2011 - Non Attributed to Unsafe Abortion
Contraceptive prevalence (as of 2009) : 36% in women with no Education
21% among women with more than Secondary Education

Legal and Policy Status for abortion
Does a law or policy exists in the country:
- Only legal provision for Thalassaemia Major Fetus and Fetus incompatible with life.

Penalty clauses of the law
- Flogging, 30 Lashes for out of wedlock

Are the drugs for MA registered and available in the country?
- Drugs available are controlled and for hospital use - Misoprostol

Delivery of Abortion Services
- Only for incomplete abortion/missed abortions.
- By registered OB/GYN.

Successes and Challenges in Reducing Unsafe Abortions
- No adequate study/data of unsafe abortions.
- One Anecdotal report
- Magnitude of out of wedlock deliveries gives a clue.
- Failure to recognize the issue.
Preventing unsafe abortion to reduce maternal mortality

Report of the regional meeting held in Kathmandu, Nepal
Annex 2.3
Country Presentation - Pakistan

General Information
- Country population - 173.51 million (NIPS 2012)
  - Urban population - 63.05 million
  - Rural population - 110.46 million
- Number of women of reproductive age: 38.19 Million (22% of total population)
- Nearly one in four births in Pakistan are unplanned*
- 25% of women have an unmet need for family planning*
- Approximately 1 in 89 women will die of maternal causes*

*Source: PDHS 2006-07

- In the only national study on abortion incidence, the Population Council estimated 890,000 induced abortions occurred in 2002 and the abortion rate was 29 per 1,000 women aged 15-49.*
- Most women in Pakistan who have induced abortions are 30 years or older, are nearing the end of childbearing years and typically have three or more children.*
- The national study estimated 197,000 women were hospitalized for complications of unsafe abortion.*
- The PDHS 2006-07 estimated 5.6% of maternal deaths are attributed to abortion-related complications.


![Maternal Mortality Ratio](image1)

![Causes of Maternal Mortality (PDHS-2006-07)](image2)

*Source: Planning Commission
Legal and Policy Status for abortion

- Until 1990 the Pakistan Penal Code (PPC) criminalized abortion, unless it was performed in “good faith” to save the woman’s life.
- Following a 1989 Supreme Court decision, Pakistan revised the colonial-era Penal Code and abortion law to better conform to the principles of Islamic law and teachings with regards to offences against the human body.
- Abortion is now legal to save the woman’s life or to provide necessary treatment, but the conditions for legal abortion depend on the developmental stage of the fetus.
- Abortions are allowed in order to save the woman’s life or to provide necessary treatment before the fetus’s organs are formed. Afterwards, abortions are permitted only to save the woman’s life.
- Islamic scholars have usually considered that organs are formed by the fourth month of gestation (120 days – concept of ensoulment).
- Before any organs are formed the offence requires penalties under civil law (ta’zir) (imprisonment for up to 3-10 years).
- After organs are formed, traditional Islamic penalties in the form of compensation to heirs of victim (diyat) are imposed, imprisonment may be prescribed, as well.

(Source: Abortion in Pakistan, In Brief, New York: Guttmacher Institute, 2009, No. 2.)

Delivery of abortion services

- In Pakistan abortion-related care is provided by a wide variety of personnel from medical doctors to traditional practitioners often under unsafe conditions. There is no legal or policy framework limiting service provision to any specific cadre of healthcare provider.
- The 2002 national study estimated that 7% of poor rural women obtained abortions from doctors, 39% from nurses/ midwives/Lady Health Visitors and 42% from dais (traditional birth attendants). Among non-poor urban women 49% went to doctors, 33% to nurses/ MW/LHVs and 9% to dais; among poor urban woman 45% went to nurses/MW/LHVs, 34% to dais and 10% to doctors.
- D&C was reported as the most commonly performed method.
• Services are available through both public and private sector facilities, however due to prevailing stigma, most women resort to desperate and dangerous measures including clandestine clinics to obtain abortion care.

• Cost is a clear indicator of inequity in Pakistani women’s access to safe abortion - more affluent women can afford expensive safer procedures, but poor women must make do with riskier procedures from untrained personnel. (Source: Guttmacher Institute)

• Public sector facilities report monthly D&C procedures (therapeutic abortion/PAC) through the district health information system (DHIS), but data is incomplete and records poorly maintained.

• National Service Standards are formulated for RH/FP services, but there are no national standards, guidelines or training manuals for safe abortion/postabortion care (PAC). An in-service EmONC training manual does include PAC.

• MVA is available in the market, but not widely used and is not included in the Essential Equipment List.

• Misoprostol is registered for the prevention and treatment of postpartum hemorrhage, but is not included in the Essential Drug List. An inexpensive local product is available.

• Postabortion family planning services are generally provided through outpatient clinics, NGO providers, or Population Welfare Department outlets.

**Successes in Reducing Unsafe Abortions**

• Launch of the Pakistan Alliance for Postabortion Care (PAPAC) in 2009 by Ipas and collaborating partners - a network of major stakeholders established to foster synergy, avoid duplication, improve and expand the quality of available PAC services, enhance community mobilization and create a national enabling environment

• Opportunity to upscale new and improved technologies (MVA and misoprostol)

• Expanded access to high quality services through improved PAC clinical trainings and Values Clarification and Attitude Transformation (VCAT) workshops

• Research informing programs and policy – significant donor interest in issue

• Public sector willingness to integrate PAC in the health system

• SOGP, MAP, PNC – obgyn, midwifery and nursing bodies' engagement with issue

**Challenges in Reducing Unsafe Abortions**

• Significant stigma attached to abortion and related care

• Providers’ misconceptions, personal biases and negative attitudes towards clients and referrals

• Lack of adequate trainings, low caseload for clinical practice and limited follow-up

• Existing gaps in pre-service and in-service curricula and training of midlevel service providers

• Unregulated private sector

• Lack of sustainable supply of required equipment

• Misoprostol only registered for PPH and MVA not included in Essential Equipment list

• Compromised quality of data and use in planning
Preventing unsafe abortion to reduce maternal mortality

Report of the regional meeting held in Kathmandu, Nepal
Annex 2.3
Country Presentation - Timor Leste

TL Demographic Profile 2010

TIMOR LESTE
5 regions
13 districts
65 sub districts
442 village
2225 hamlet

Health Services / systems
1 National Hospital
5 referral / regional hospitals
65 community health centers
184 health posts
465 Integrated Community Health service
28 Private clinic

Legal and Policy Status for abortion

- Article 141 Interruption of Pregnancy
  - Any person who performs abortion through whatever means and without the consent of the pregnant woman shall be sentenced to 2-8 yrs imprisonment.
  - Any person who performs abortion through whatever means and with the consent of the pregnant woman shall be sentenced to 3 years imprisonment
  - Any pregnant woman who consents to an abortion procedure by any other individual or induces an abortion as a result of her own deeds or those of a third party shall be sentenced to up to 3 years imprisonment.
  - The provisions on the previous items are not applicable in cases when the interruption of pregnancy is the only means to counter the risk of death or irreversible lesion to the body and physical or psychological health of the mother or the fetus, as long as the procedure is authorized and monitored by a medical team and performed by a doctor or health professional in a public health institution with the consent of the pregnant woman and/or her life partner
  - The provision of item 4 of this article will be the object of a separate regulation.

- National Reproductive Health Strategy 2004-2015:
  - The Strategy categorises reproductive health into, Safe Motherhood, Family Planning, General Reproductive Health and Young People.
  - Abortion is mentioned in connection with adolescent health and in terms of emergency obstetric care under Safe Motherhood.
Medical and Surgical abortion is illegal in the country
No drugs are registered for Medical Abortion purposes

Who can provide abortion services:
Abortion services are being provided by midwives and general doctors who have undergone EMONC training

Where are legal abortion services available?
There are no legal abortion services available

Delivery of Abortion Services

Availability of National standards, guidelines and training manuals:
Abortion care guideline is integrated under the EmOC training package manual
EmOC facilities and equipments are being used for the abortion services

All health facilities with a trained BEmONC provider including referral hospitals, CHCS and health posts provide post-abortion care services
Family planning counseling is done to clients immediately after a post abortion service but the service is provided after menses.
Data collection, monitoring and reporting for abortion services: though data are collected most of the time they are usually under reported.

Successes in Reducing Unsafe Abortions

SUCCESS of Timor Leste with regard to abortion care or post-abortion care
Incorporation of abortion services in EmOC

Challenges in Reducing Unsafe Abortions

CHALLENGES with regard to abortion care or post-abortion care
Restrictions of the TL Abortion law (Article 141)
Strong religious influence
Strong cultural belief of timorese families
Low knowledge of the community
Lack of clinical standard guideline for service providers
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

Annex 2.4

Country Presentation - Thailand

General Information

Country population : about 65 millions
Number of women : about 14 millions of reproductive age

The Contraceptive Prevalence Rate in Thailand 1978-2009

Available Sources of MMR in Thailand

<table>
<thead>
<tr>
<th>Sources</th>
<th>MMR</th>
<th>Survey/Study Year</th>
<th>Geographic coverage</th>
<th>Method Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital registration</td>
<td>817.4 (1937)</td>
<td>Annually, since 1937</td>
<td>Whole country</td>
<td>Direct estimate</td>
</tr>
<tr>
<td></td>
<td>12.2 (2007)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RAMOS* (Reproductive Age Mortality Survey)</td>
<td>44.3, 43.9, 36.5, 36.4</td>
<td>1995, 1996, 1997, 1998</td>
<td>12 provinces</td>
<td>Direct estimate (investigate COD)</td>
</tr>
<tr>
<td>Safe Motherhood Program</td>
<td>14 - 27</td>
<td>1995 - 2002</td>
<td>Whole country</td>
<td>Direct estimate</td>
</tr>
<tr>
<td>Special Study from TDRI</td>
<td>41</td>
<td>2006</td>
<td>Whole country</td>
<td>Multiple sources</td>
</tr>
</tbody>
</table>
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

MCH Situation (1)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Targets</th>
<th>1990</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR (:100,000 LBs)</td>
<td>18</td>
<td>29.0</td>
<td>10.8</td>
</tr>
<tr>
<td>IMR(:1,000 LBs)</td>
<td>15</td>
<td>24.6</td>
<td>15.6</td>
</tr>
<tr>
<td>Under 5 MR</td>
<td>2/3 of 1990</td>
<td>32.0</td>
<td>14.0</td>
</tr>
<tr>
<td>Birth Asphyxia</td>
<td>30</td>
<td>60.9</td>
<td>25.0</td>
</tr>
<tr>
<td>Low Brth Weight (%)</td>
<td>7</td>
<td>9.9</td>
<td>8.3</td>
</tr>
</tbody>
</table>

Source: Bureau of Health Promotion
Note: MMR = 44/100,000 LBs reported by TDRI

Causes of Maternal Deaths

<table>
<thead>
<tr>
<th>Causes of Maternal Death</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heamorrhage</td>
<td>21.65</td>
</tr>
<tr>
<td>2. Toxemia of Pregnancy</td>
<td>12.37</td>
</tr>
<tr>
<td>3. Sepsis</td>
<td>4.12</td>
</tr>
<tr>
<td>4. Amniotic embolism</td>
<td>12.37</td>
</tr>
<tr>
<td>5. Others</td>
<td>32.54</td>
</tr>
</tbody>
</table>

Legal and Policy Status for abortion

- Does a law or policy exists in the country: Yes
- Indications for which abortion is legal:
  1. Rape
  2. Maternal health
     - physical and mental

- Consent issues
  - need 2 physicians’ opinion in case of mental health disorder

- Recommended gestational period for abortion:
  - Less than 12 wks: SA
  - Less than 9 wks: MA

- Status of Medical and Surgical abortions in the country
  - SA: available
  - MA: research only

- Are the drugs for MA registered and available in the country?
  - MA: under registration process

- Who can provide abortion services:
  - doctor only

- Where are legal abortion services available?
  - hospital and clinic

- Requirements and process for certification/accreditation of facilities for provision of abortion services and for undertaking training for abortion service
  - No
• Requirements of registration/recognition for provision of abortion services for providers and/or pharmacies etc.
  ■ No

**Delivery of Abortion Services**

• Availability of National standards, guidelines and training manuals
  ■ No

• Training requirements for safe abortion:
  ■ Facility/training center requirements
  ■ Providers
  ■ Training material and equipment etc.

• Where and by whom are post-abortion care services available?
  ■ Hospital and by doctor/ nurse

• Is post abortion family planning services offered or available?
  ■ Yes

• Data collection, monitoring and reporting for abortion services
  ■ No (all providers just are asked to send the service’s report to Thai Medical Council)

**Successes and Challenges in Reducing Unsafe Abortions**

<table>
<thead>
<tr>
<th></th>
<th>Success</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abortion care</strong></td>
<td>• Some movement for SA-MVA \n                         MA-under registration</td>
<td>• Attitude of provider \n                         • Access to safe abortion services</td>
</tr>
<tr>
<td><strong>Post abortion care</strong></td>
<td>• Very few (Most of abortion cases were performed by NGOs and clinic)</td>
<td>• Attitude of providers \n                         • Service guideline management system</td>
</tr>
</tbody>
</table>
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

Annex 2.4

Country Presentation - DPR Korea

General Information

Population : 24 052 231
(female:12 330 393, male:11 721 838)
(“Health Status Report”, 2009, &
“Population Census Data” 2008)

Northeast of : 223 370 km
Asia Area

Capital City : Pyongyang

Province : 9

City : Composed of district and Dong
Province : Composed of city and county,
“up, gu, ri"

Abortion Ratio
121 per live births 1000
(CBS, Reproductive Health Survey, 2006, 45p)
(Medium Term Strategic Plan for Health Development, DPRK)

Abortion Ratio(%)
(“Reproductive Health Survey”, 2002)

Maternal Mortality Ratio
(“Health Status Report”, 2011)

105 97 90 85.1 50
10 20 40 60 80 100 120
Legal and Policy Status for Abortion

- Does a law or policy exists in the country:
  - Government provides the legal guarantee for abortion
  - “Law of Public Health” (Vol. 3) presents as follows;
  - “Midwife should, in relation with obstetrician in charge of clients, provide the abortion care for 100% of women who wants or whose pregnancy influences on her health badly”
- Indications for which abortion is legal:
  - Legally, only surgical abortion care can be provided (EVA, expansion and curette, expansion and exclusion)
- Consent issues
  - No limitation for consent
- Penalty clauses of the law
  - Legal penalty applied, but not paid for it
- Recommended gestational period for abortion:
  - Performed up to 7 months according to the demand of client
- Status of Medical and Surgical abortions in the country?
  - In general, abortion care by surgical method (i.e. EVA) has been provided, and since January 2007, MVA has also been introduced into the several pilot areas.
  - Recently, medical abortion is undertaken in 4 pilot areas.
  - In addition, mobile team for safe abortion provides the MVA abortion care through mobile care posts at PHC level in 21 counties.
- Are the drugs for MA registered and available in the country?
  - Yes (but available in pilot areas)
  - However, the drugs are not registered in national/sub-national essential medicine lists and not procured in the market.
  - Availability of the drugs is only by support by IFPA
- Who can provide abortion services: MD
- Where are legal abortion services available?
- County/district hospitals or higher-level ones with small-scaled operating theatres.
- Requirements and process for certification/accreditation of facilities for provision of abortion services and for undertaking training for abortion service
- Requirements of registration/recognition for provision of abortion services for providers and/or pharmacies etc.
- Health workers should be trained on abortion-relevant training course after educational course in medical college. (Doctors without qualification have definitely no eligibility to conduct the abortion.)
- Graduates of medical college can be trained on abortion for 3 months in the county/district hospitals or higher-level ones they are engaged by trainers.

**Delivery of Abortion Services**
- Availability of National standards, guidelines and training manuals
  - “Guideline on safe abortion care” (IFPA) translated and introduced.
  - National guidelines
  - National standards are involved in Obstetric Textbooks and references
- Training requirements for safe abortion:
  - Facility/training center requirements
  - Providers
  - Training material and equipment etc
M & E Indicators

Registration System of KFPA
- Abortion Ratio (artificial abortion ratio per 1000 women in reproductive age)
- Maternal Mortality after abortion (absolute number)
- Ratio of health workers trained on safe abortion care
- Ratio of hospitals to provide the folic acid after abortion
- Ratio of hospitals to provide the family planning care after abortion
- Ratio of hospitals to provide the family planning counseling after abortion
- Ratio of women with knowledge about impact of unsafe abortion

Successes in Reducing Unsafe Abortions

Activity(1)
Advocacy
- Central Discussion
- Strengthening the collaboration with other international agencies
- Establishment of collaboration relation with social organizations at every level and hospitals
- Conduction of workshop on various fields for providing the quality safe abortion care

Activity(2)
IEC activity
- Development and distribution of IEC materials on safe abortion
- Reflecting the safe abortion to regular publication
Activity (3)

Capacity Strengthening

- Oversea training, development of guideline
- Local training, experiences sharing
- Procurement of SE (MVA, cervical extractor, medicine, consumables, contraceptive medicines and etc)

Activity (4)

Service Delivery

- Before service delivery: conduct the survey on the needs of clients on safe abortion and abortion-related complications
- Service delivery by MVA
- Referral service for management of complications
- Post-abortion care on every client within 2 weeks after abortion

Strengthening the Capacity of Health Facilities (2006~2010)

<table>
<thead>
<tr>
<th>Health Facilities rehabilitated by MCH Project implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial blood center (including central): 7</td>
</tr>
<tr>
<td>Provincial Medical Warehouse: 5</td>
</tr>
<tr>
<td>Provincial Maternity Hospital and its OTs and DRs: 5</td>
</tr>
<tr>
<td>OTs and ICUs in provincial pediatric hospital: 5</td>
</tr>
<tr>
<td>Provincial Training Center: 2</td>
</tr>
<tr>
<td>Nursing/Midwifery Schools: 6</td>
</tr>
<tr>
<td>OTs in county hospital: 100</td>
</tr>
<tr>
<td>DRs in County hospital: 100</td>
</tr>
<tr>
<td>Emergency Units in County Hospital: 120</td>
</tr>
<tr>
<td>Laboratory rooms in county hospital: 40</td>
</tr>
<tr>
<td>Blood Units in county hospital: 40</td>
</tr>
<tr>
<td>Ri hospital/polyclinics: 1200</td>
</tr>
</tbody>
</table>
Result(1)

Development of guidelines and references and conduction of training

- Guideline “Comprehensive Safe Abortion Care”
- “Usage of MVA”
- “Medical Abortion”

Result(2)

IEC Activity on safe abortion and its care

- # of activity : totally 445
- Participants : 13,484

Challenges in Reducing Unsafe Abortions

- Insufficient SE and medicines at PHC level
- Low awareness of health care providers on modern method for safe abortion care
- Not conduct the timely referral of the emergent patients
- Lack of transportation vehicles
Annex 2.4

Country Presentation - Myanmar

General Information

- General Population : 59.78 million
  Source: Health in Myanmar, 2012
- Number of women of reproductive age : 15.03 millions
- Health Expenditure : 2%
  Source: National health account, DHP, MOH
- TFR : 2%
  Source: Fertility and Reproductive Health Survey, 2007

Analysis of cause of death (2000-2011)

<table>
<thead>
<tr>
<th></th>
<th>Obstetric Haemorrhage</th>
<th>Eclampsia &amp; severe PE</th>
<th>Obstructed labour &amp; rupture uterus</th>
<th>Sepsis</th>
<th>Abortion related complications</th>
<th>Indirect cause</th>
<th>Miscellaneous</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
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<td>1</td>
<td>0</td>
<td>1</td>
<td>19</td>
<td>2</td>
<td>1</td>
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<td>2001</td>
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<td>0</td>
<td>1</td>
<td>12</td>
<td>1</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>2002</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>3</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>2003</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>14</td>
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<tr>
<td>2004</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>11</td>
<td>3</td>
<td>0</td>
<td>25</td>
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<tr>
<td>2005</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>11</td>
<td>0</td>
<td>1</td>
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<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>12</td>
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<tr>
<td>2007</td>
<td>4</td>
<td>1</td>
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<td>0</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>18</td>
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<tr>
<td>2008</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>14</td>
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<td>23</td>
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<td>2009</td>
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<td>2</td>
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<td>2010</td>
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<td>1</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>2011</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>16</td>
<td>1</td>
<td>5</td>
<td>126</td>
<td>20</td>
<td>9</td>
<td>210</td>
</tr>
</tbody>
</table>

Source: North Okkalapa General Hospital
Legal and Policy Status for Abortion in Myanmar

- Under the Penal Code of Myanmar, abortion is generally illegal (Restricted)
- Any person performing an abortion is subject to up to three years’ imprisonment and/or payment of a fine.
- A woman who induces her own abortion is subject to the same penalties.
- If the abortion results in the death of the woman, punishment is for 10 years and a fine.

Penalty clauses of the law
MPC Section 312

Whoever voluntarily causes a women with child to miscarry, if such miscarriage be not caused in good faith for the purpose of saving the life of the women, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both: and if the woman be quick with child shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.

Explanation – A woman, who causes herself to miscarry, is within the meaning of this section.
Legal and Policy Status for Abortion in Myanmar

- Status of abortion is “Restricted” in Myanmar.
- Indications for which abortion is legal: Medical Ground and Crime Afflicted (e.g. Rape)
- Consent issues:
  - Usually accept the advice of respective doctors especially OB-Gyn and Medical Board to decide will be organized by DoH.
  - Woman herself, husband/partner, community leader (sometime, attendance who come along with her)
- Recommended gestational period for abortion: 22 weeks
- There are “No”
  - Status of Medical and Surgical abortions in the country
  - the drugs for MA were already registered and available in the country
- Public Doctors provide abortion services but private doctor is not legal.
- Legal abortion services are available at Public Hospitals under the supervision of specialist personnel.
- No specific training for safe abortion however Training for PAC in some townships.

Delivery of Abortion Services

- Post-abortion care services – at all health facilities by health care providers (eg. Doctors, midwives)
  - Emergency Treatment
  - Post abortion counseling (including Birth spacing)
  - Linking with other RH services
- Data collection, monitoring and reporting for abortion services are done on those who attended health facilities

Successes and Challenges in Reducing Unsafe Abortions

<table>
<thead>
<tr>
<th>Success</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political commitment as a priority issue</td>
<td>Cultural barrier</td>
</tr>
<tr>
<td>Collaboration with other stakeholder</td>
<td>Limited resources</td>
</tr>
<tr>
<td>Attitudinal change</td>
<td>Socio – economic problems</td>
</tr>
<tr>
<td></td>
<td>Limited RH information especially birth spacing and sex education among the youth</td>
</tr>
<tr>
<td></td>
<td>Lack of Proper Advocacy (parliamentarians, Health Decision Makers for the issue)</td>
</tr>
</tbody>
</table>
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal
General Information: Lao PDR

- Women of reproductive age: 1,677,200 (UNFPA, 2010)
- Abortion rates specific to Lao PDR are not available. Guttmacher Institute (2012) estimates abortion rates in Southeast Asia as 36 per 1,000 women
- The proportion rate of maternal mortality associated with unsafe abortion specific to Lao PDR are not available.

Causes of Maternal Death

Maternal Mortality in Lao PDR

Contraceptive Prevalence Rate in Lao PDR
Legal and Policy Status for abortion

- Elective abortions are banned in Laos, where they are considered a violation of Article 85 of the criminal law for both the doctors and women involved. Under the code, abortion is generally punishable between 2 to 10 years imprisonment. However, an abortion can be performed to save a women’s life.
- No MA Drugs Registered in the Country.
- Therapeutic abortion services can be provided in Central and Provincial Hospitals by medical doctor or Gynaecologist.
- Currently there is no requirement and process for certification/accreditation of facilities for provision of abortion services and for undertaking training for abortion service.
- No requirements of registration/recognition for provision of abortion services for providers and/or pharmacies.

Delivery of Abortion Services

- No National standards, guidelines and training manuals.
- Training requirements for safe abortion: No requirement.
- Post-abortion care services are available in almost all provincial hospitals and some districts hospital and done by MD or Gynecologist in central and provincial hospital but may be done by Medical Assistant in some districts where MD are not available.
- Post abortion family planning services offered and available in almost all districts and all provincial hospitals.
- Available Data collection about total cases of abortion in respective provincial hospital, induced and spontaneous abortion.

Successes and Challenges in Reducing Unsafe Abortions

- First EOC training in Lao PDR in 2003 (WHO-UNFPA) including PAC (MVA and Family planning counseling) in two provinces.
- Currently EOC training in 14 of 17 provinces of Laos.
- Need to expand EmONC training to all district hospital plus providing training material and equipment supply for the medical center where there have PAC services.
Topics

- Magnitude/burden of unsafe abortion
- Legal status in eleven member states
- Services (or lack thereof)

The Burden

WHO maintains a DATABASE, contributed by a wide range of sources

“Unsafe abortion – global and regional estimates of incidence of unsafe abortion and associated mortality (year)”

- no data, therefore estimates, assumptions, adjustments, indicative and not precise, only regional and not country
- complex methods (indirect, different denominators, different geog Regions)

Measurements of unsafe abortion

- Absolute numbers
- Prevalence : Rate – per 1,000 women reprod age
  Ratio – per 100,000 livebirths
- Mortality : Rate – per 1,000 women reprod age
  Ratio – per 100,000 livebirths as % of MMR
- Case fatality : Deaths due to unsafe abortion among unsafe abortion cases

Reports

1993
1997

- 210 Million pregnancies
  - 130 million livebirths
  - 80 million abortion
    - 38 million spontaneous
    - 42 million induced
  - 22 million unsafe
  - 66,500 deaths (13% MMR)
  - 22 million safe

UN (geographical) REGIONS
The SEA countries fit into three Regions
- South Central Asia: BAN, BHU, IND, MAV, NEP, SRL
- South Eastern Asia: IND, MMR, THA, TLS
- Eastern Asia: DPR Korea

Estimated annual number of unsafe abortio per 1000 women aged 15-44 years, by subregions, 2008

Unsafe Abortions per 1000 women aged 15-44 years
- 30 or more
- 20-29
- 10-19
- 1-9
- None / negligible
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

Estimated annual number of unsafe abortion per 1000 women aged 15-44 years, 1990 and 2008, by subregions.

Source: Table 5 and WHO, 1993

Estimated annual number of maternal deaths due to unsafe abortion per 100 000 live births, by subregions, 2008

By WHO Region (SEARO) - 2003

<table>
<thead>
<tr>
<th>Cases</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>7.2 million</td>
</tr>
<tr>
<td>Per 1 000 women</td>
<td>19</td>
</tr>
<tr>
<td>Per 100,000 livebirths</td>
<td>19</td>
</tr>
<tr>
<td>Number</td>
<td>21,800</td>
</tr>
<tr>
<td>Per 100 000 LB</td>
<td>60</td>
</tr>
<tr>
<td>% of maternal deaths</td>
<td>13%</td>
</tr>
</tbody>
</table>

By WHO Region (SEARO) – 2008 (Cases)

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
<th>Per 1000 women</th>
<th>Per 100 LB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low income</td>
<td>5 260 000</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Low middle income</td>
<td>2 150 000</td>
<td>28</td>
<td>39</td>
</tr>
<tr>
<td>Total</td>
<td>7 420 000</td>
<td>18</td>
<td>19</td>
</tr>
</tbody>
</table>
By WHO Region (SEARO) – 2008 (deaths)

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
<th>Per 1000 women</th>
<th>Per 100 LB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low income</td>
<td>100</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td>Low middle income</td>
<td>600</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>1100 (?)</td>
<td>7</td>
<td>10</td>
</tr>
</tbody>
</table>

Unsafe Abortion (3 Reports)

<table>
<thead>
<tr>
<th></th>
<th>CASES</th>
<th>DEATHS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Global</td>
<td>SEARO</td>
</tr>
<tr>
<td>2000 (4th edition)</td>
<td>19 million</td>
<td>7.7 million</td>
</tr>
<tr>
<td></td>
<td>(14)</td>
<td>(22)</td>
</tr>
<tr>
<td>2003 (5th edition)</td>
<td>19.7 million</td>
<td>7.2 million</td>
</tr>
<tr>
<td></td>
<td>(14)</td>
<td>(19)</td>
</tr>
<tr>
<td>2008 (6th edition)</td>
<td>21.5 million</td>
<td>7.42 million</td>
</tr>
<tr>
<td></td>
<td>(14)</td>
<td>(18)</td>
</tr>
</tbody>
</table>

( ) = Incidence/1 000 women
( ) = % of MMR

Deaths due to Unsafe Abortion  (using UN Region – “Asia” as proxy for SEAR)

<table>
<thead>
<tr>
<th>Sub Region of Asia</th>
<th>2000</th>
<th>2003</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>South Central</td>
<td>28,700</td>
<td>24,300</td>
<td>14,000</td>
</tr>
<tr>
<td>South Eastern</td>
<td>4,700</td>
<td>3,200</td>
<td>2,300</td>
</tr>
<tr>
<td>Western</td>
<td>600</td>
<td>1,000</td>
<td>600</td>
</tr>
<tr>
<td>Total ASIA</td>
<td>34,000</td>
<td>28,500</td>
<td>16,900</td>
</tr>
</tbody>
</table>

Deaths 2008

16,900 deaths a marked decline from 2003

Contributed by (sub-regions)

- **Eastern**: China, DPRK, ROK, Japan, Mongolia
- **South Central**: Afghan, BAN, BHU, IND, Iran, MAV, NEP, Pakistan, SRL, Central Asia republics
- **South Eastern**: Brunei, Cambodia, INO, Lao, M’sia, MMR, Phil, Spore, THA, TLS, Vietnam
- **Western**: 20 countries (EURO, EMRO)
**Legal Status**

Grounds on which abortion is permitted in SEA Region Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>To save a woman’s life</th>
<th>To preserve a woman’s physical health</th>
<th>To preserve a woman’s mental health</th>
<th>In case of rape or incest</th>
<th>Because of foetal impairment</th>
<th>For economic or social reasons</th>
<th>On request</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPR Korea</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nepal</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>India</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Thailand</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Maldives</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bhutan</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bangladesh</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X*</td>
</tr>
<tr>
<td>Myanmar</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


**Services**

- **Standards**: underlying principles, essential requirements for providing equitable access
- **Guidelines**: Evidence-based instructions for delivery of service (WHO guidelines)

No national standards and guidelines for Indonesia, Maldives, Myanmar, Sri Lanka, Timor Leste

**Dynamics are complex....**

- Relationship between CPR and need for abortion – not always correlated
- Relationship between liberal laws and incidence – yes generally, but there are exceptions (Eastern Europe)

*Both relationships have complex technical, socio-cultural and health system factors*
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal
Unsafe abortion .......the global scenario

Dr Bela Ganatra
Lead Specialist; PUA
Department of Reproductive Health
World Health Organization

The Global Reality

- 43.8 million induced abortions, 22.2 million are unsafe
- 1 in 10 pregnancies ends in an unsafe abortion
- Induced abortion rates decreased in all major regions of the world since 1995 but the proportion of abortions that are unsafe increased from 44% in 1995 to 49% in 2008.
- Unsafe abortion seen in 70% of countries where 64% of women live & 76% of births (pregnancies) occur

Unsafe abortion rates over time: 2008 compared to 1990

![Unsafe abortion rates over time: 2008 compared to 1990](image)
Unsafe abortion has become less unsafe: Case Fatality Rate (2008 compared to 1990)

Whatever the law .......induced abortion exists

Unsafe abortion-related deaths per 100000 live births, 2008

Unsafe abortion: 13% of all maternal deaths

CFR for legal induced abortion 0.6 /100,000 abortions
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

Why?

What’s different?

2003 2012

Process of updating

- Extensive involvement of multi disciplinary experts from around the world
- ‘Scoping’ of areas that needed updating
- Systematic review of evidence
- The recommendations reflect the areas where experts guided us that updating was needed based on new evidence
- Need to see the guidance in toto and not just the summary recommendations
Safe abortion …….its legal and necessary

- Preventing unsafe abortion has several components
  - Sexuality education
  - Contraception
  - Safe abortion
  - Care for complications

- All are needed
  - Contraception alone does not eliminate abortion need
  - PAC is important but not sufficient
- In almost every country in the world abortion is legal

Public health and human rights

- There is a strong public health rationale for providing safe abortion services
  - Reduction in unsafe abortion, reduction in maternal mortality, reducing disability and morbidity, achieving MDG 5
- There is an equally strong human rights rationale
  - Growing number of UN treaty monitoring body general comments & concluding observations, as well as regional treaty provisions and regional court decisions related to abortion.

Appropriate technologies

- Appropriate technologies and evidence based care
- Vacuum aspiration (to 12-14 weeks)
- Medical abortion with mifepristone and misoprostol (to 9 weeks ; 9-12 weeks and beyond 12 weeks)
- D&E (beyond 12-14 weeks)

Services, systems, sensitivity

- Systems and holistic approach
  - Policy makers, program managers, service providers, advocates, human rights persons
- Services at primary care level
- Care needs to be available beyond the first trimester

Care that is sensitive to women's needs

- Respect for dignity, autonomy, choice, confidentiality
- Women need abortion care even beyond the first trimester
- Adolescents have special needs as do rape survivors, women living with HIV, poor women etc.
What next?

- Tool for evidence based decision making related to abortion care
- Use towards development or updating of standards and guidelines and in implementing ‘safe abortion care’ in countries
- Review evidence and update as needed in 4 years in time

I feel bad also at what I did. People tell me it’s a sin. They say I will have trouble in future pregnancies. But what to do? I cant have a child now. You don’t know my family, my problems. What can I tell you?

32 year urban woman speaking about her feelings after an abortion (Data from a research study on medical abortion done in Pune India, in 2002)
Annex 5

Abortions in Adolescents: Can we afford to ignore them!

Dr Neena Raina
Regional Adviser
Child and Adolescent Health
World Health Organization

Reality check

- 17 years old girl resident of Urban low income area, school drop out
- Treated for nausea, vomiting and general feeling of un-wellness by unqualified GP for 8 days: Received antibiotics for suspected typhoid fever
- Contacts Qualified GP who gets some tests done and suggests non-specific treatment and calls for follow up with the reports. Reports normal but vomiting has worsened.
- Treating GP asks for last menstrual period – Ans. 2 months back. Does urine pregnancy test which is positive. Patient hesitantly reports sexual engagement about 6 (?) months back
- Treating GP suggests that parents be brought because ultrasound and further course of action would need to be discussed
- The girl informs that mother is out of town and father could be involved. She gives consent to the doctor to inform her father and discuss. She insists that father should not be harsh on her.
- Fortunately father takes the news in a balanced manner. Ultrasound reveals 12 weeks pregnancy. Father request help for arranging MTP in a private hospital.
- GP contacts a few nursing homes who refuse because the government is very strict on 2nd trimester MTP on account of possibility of sex selective abortion
- One small hospital agrees for evacuation under spinal / GA for package of Rs 13,000 (USD 300) and appointment is fixed
- Mother comes back and refuses MTP and says she would like to try medicines

How many unsafe abortions occur in adolescents?

- Globally, about 3.2 million unsafe abortions occur every year among girls aged 15-19 years - most in developing countries. (2008 estimates)
- Unsafe abortions contribute to maternal mortality in adolescents as well as to lasting health problems in many of those who survive
Where do unsafe abortions occur in adolescents?

**Annual estimate of unsafe abortions**

*Asia: 2008: 10.8 million (2003: 9.8 million)*

Source: WHO Estimates 2008

Adolescent pregnancies
Globally, 11% of all pregnancies
Adolescent births are high in some SEA countries

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2008 %</th>
<th>2000 %</th>
<th>No of Unsafe abortions in 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>11</td>
<td>9</td>
<td>1.1 millions</td>
</tr>
<tr>
<td>20-24</td>
<td>23</td>
<td>23</td>
<td>2.5 million</td>
</tr>
</tbody>
</table>

Iqbal Shah and Elisabeth Ahman, RH Matters 2012

South Asia looks quite ‘pregnant’ with adolescent births

[Map of world showing high adolescent births in South Asia]
Adolescent pregnancy: Variety of circumstances

- Sex within marriage
- Sex outside a Recognized union
- Consensual sex: - Within or outside marriage
- Non-consensual sex

Planned / Wanted Pregnancy

Unplanned / Unwanted Pregnancy

Underlying socio-cultural factors influencing adolescent pregnancy

- level of education
- urban/rural residence
- ethnicity
- cultural values and norms including gender imbalance
- socioeconomic status

These factors also determine if adolescents would seek timely and safe abortion services

In many individuals, sexual activity begins in adolescence

- Age at puberty is dropping
- Age at marriage is gradually rising
- Rates of premarital sex are increasing
- Contraceptive use still low
- Unmet need for contraception is high

Few young people receive adequate preparation for their sexual lives.

- Few young people receive adequate preparation for their sexual lives. This leaves them potentially vulnerable to coercion, abuse and exploitation, unintended pregnancy and sexually transmitted infections (STIs), including HIV.”

Pregnancy in adolescents

- Adolescents are less likely to be able to prevent pregnancy, if they wanted
- Adolescents are less likely to be able to access legal and safe abortions, if they wanted to terminate their pregnancies
- They are likely to report late – usually in second trimester, increasing the complications of abortion
- Unprepared & unable to protect themselves
- Unable to refuse unwanted sex or to resist coerced sex

Adolescent childbearing in SEA

Early childbearing follows early marriage:
Percentage of women aged 20-24 years married by 18 years of age

Contraceptive use remains low

Unmet Needs of Contraception are high
Demand and unmet need for contraception among adolescents aged 15-19

Most perceive access of contraception from chemist
Preception of Adolescents and Youth on the Source of getting Contraceptive during their need
Birth to adolescents as a percentage of all births in SEA Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Total number of births</th>
<th>Birth to adolescents as a percentage of all births</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All ages</td>
<td>15-19 year old</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>4,220,936</td>
<td>955,418</td>
</tr>
<tr>
<td>Bhutan</td>
<td>74,208</td>
<td>6,977</td>
</tr>
<tr>
<td>India</td>
<td>25,160,316</td>
<td>2,284,033</td>
</tr>
<tr>
<td>Indonesia</td>
<td>4,494,155</td>
<td>591,204</td>
</tr>
<tr>
<td>Maldives</td>
<td>10664</td>
<td>913</td>
</tr>
<tr>
<td>Myanmar</td>
<td>1,180,284</td>
<td>71,586</td>
</tr>
<tr>
<td>Nepal</td>
<td>810,471</td>
<td>148,891</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>328,257</td>
<td>21,190</td>
</tr>
<tr>
<td>Thailand</td>
<td>1,169,682</td>
<td>150,970</td>
</tr>
<tr>
<td>Total</td>
<td>37,448,973</td>
<td>4,231,182</td>
</tr>
</tbody>
</table>


Barriers to the provision & utilization of contraceptives by adolescents

- **Not available!**
  Contraceptive services are not available to anyone

- **Not accessible!**
  “Contraceptive services are available, but I am not able to obtain them.”

- **Not acceptable!**
  “Contraceptive services are available. I can obtain them. But I do not want to.”

Barriers to the provision & utilization of contraceptives by adolescents in low & middle income countries
More births are unwanted in adolescents Exception: BAN, IND, INO, TLS

Adverse outcome - Mortality

Source: Bangladesh DHS 2007; India NFHS-3 2005-06; Indonesia DHS 2007; Nepal DHS 2011; Sri Lanka DHS 2005-06; Timor-Leste DHS 2009-10; Maldives DHS 2009. Guttmacher Institute 2010; 2.7 million unintended pregnancies among adol girls each year- mainly in married adolescents

Source: Bangladesh DHS 2004; India NFHS-3 2005-06; Indonesia DHS 2002-03; Nepal DHS 2006; Sri Lanka DHS 2000; Timor-Leste DHS 2003


Source: Safe Motherhood 1998; For India-Krishna 1995
Abortion situation SEA region

Abortion Laws not favorable to adolescents
- In none of the SEAR countries abortion is illegal
- Liberal India, Nepal and DPR’K
- Restricted in the rest of the countries (to save women’s life, rape or congenital malformation)
- Restrictions due to age - under 18 are minor

Knowledge about legality of abortion is poor

<table>
<thead>
<tr>
<th>&lt; 19 yrs</th>
<th>20-24 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Unmarried</td>
</tr>
<tr>
<td>24</td>
<td>31</td>
</tr>
</tbody>
</table>

However, access to adolescent clients remains limited
- Consent from spouse, parent for legally minors –married or unmarried
  - Nepal: presence of parent/guardian is compulsory during the procedure if the adolescent is less than 16 years old
  - India: Consent by a parent/guardian is necessary for MTP for both married and unmarried adolescents under 18 years
- Misperception of legal requirement that spouse’s consent is mandated by law
- Belief / values that unmarried (even if legally major) clients need parent’s consent

Bangladesh
- 1.4% adolescents aged 15-19 and 3.6% young adult women aged 20-24 used Menstrual Regulation. (BDHS 2004)
- Many adolescent women hospitalized for complications of induced abortions and 15% of women rejected by MR clinics, presumably because their pregnancies were long. (Akhtar HH, 2003)
Nepal

- Only 4% adolescents utilized service of the hospital for induced abortion. But about 16% patients admitted in a hospital in Kathmandu in year 2003 for post abortion complications were adolescents.
  (Adolescent Health and Development in Nepal, A country Profile 2005)

Thailand (studies)

- Out of 13090 women with induced abortion in one year, 47 % were young women of less than 25 years of age, of which 21 % were adolescents many of whom had little or no access to contraception.
- Of 77% abortions done outside government hospitals, over 61 % were of less than 25 year olds, of whom 30 % were adolescents.
- Only 29 % of abortions outside health facility were done by health personnel (a physician, obstetrician, nurse or midwife).
- Adolescents – particularly unmarried adolescents – were more likely than older women to seek abortion from untrained providers, to undergo second trimester abortion and to suffer complications. (Warakamin et al, 2004)

India

Studies: 549 unmarried women aged 15–24 who had obtained an abortion from private (not for profit) clinic

- 91% realized they were pregnant within the first trimester.
- 84% decided before the end of the first trimester to have an abortion, but only 75% obtained abortion in this period
- 16% pregnancy had resulted from a nonconsensual sexual encounter
- Rural women, illiterate women, those who did not receive full support from their partners and those who reported a forced encounter had an increased likelihood of having a late abortion

Delayed and denied

Barriers specific to adolescent clients:
- Developmental attributes: Low self-esteem, identity crisis, lack of life skills
- Financial dependence
- Need for parental/spousal consent for legally minors
- Stigma: especially for unmarried girls

Prevention of Unsafe abortions among adolescents

- Primary prevention: Reduction in need for abortion:
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

- Prevention of unwanted pregnancy during adolescence
  - Prevent early marriage
  - Prevent early pregnancy
  - Increasing use of contraceptives including Emergency contraception
- Access to Legal and safe abortion on request

- Secondary prevention: Prompt and appropriate treatment of complications
  - Timely evacuation after incomplete abortion
  - Post abortion care
  - Referral

- Tertiary prevention: Mitigate long term damage
  - Repair of uterine injury, fistulas, manage Renal Failure

WHO 2012: Preventing early pregnancy and poor reproductive outcomes

**Preventing early marriage**

- Policy-Level Action
- Prohibit Early Marriage
- Inform and Empower Girls
- Keep Girls in School
- Influence Cultural Norms that Support Early Marriage
- Many other sectors have a role to play!

**Preventing early pregnancy**

Policy-Level Action

- Support Pregnancy Prevention Programmes among Adolescents Individual, Family and Community-Level Action
- Educate Girls (and Boys) about Sexuality.
- Build Community Support for Preventing Early Pregnancy

**Increasing the use of contraception**

Policy-Level Action

- Legislate access to contraceptive information and services
- Reduce the cost of contraceptives to adolescents
- Educate adolescents about contraceptive use
- Build community support for contraceptive provision to adolescents
- Health System-Level Action
- Enable adolescents to obtain contraceptive services
Reducing coerced sex

- Policy-Level Action
- Prohibit coerced sex
- Individual, Family and Community-Level Action
- Empower girls to resist coerced sex
- Influence social norms that condone coerced sex
- Engage men and boys to critically assess gender norms

Reduce unsafe abortion

Policy-Level Action

- Enable access to safe abortion and post-abortion services to adolescents
- Individual, Family and Community-Level Action
- Inform adolescents about the dangers of unsafe abortion and where they can obtain safe abortion services
- Increase community awareness of the dangers of unsafe abortion.
- Identify and remove barriers to safe abortion services.

Strengthening Adolescent Sexual and Reproductive Health in SEAR

<table>
<thead>
<tr>
<th>Strategic information</th>
<th>Fact sheets: Regional and country DHS/MICS: Include Ado indicators and Age disaggregation</th>
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<tr>
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<td>Supportive policies</td>
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<td>Assessment of Laws/legislation and Policies</td>
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<td>Inter-sectoral Collaboration and Partnership</td>
<td>Nutrition, Education, HIV</td>
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<td>Governments, UN agencies, Civil society, Media</td>
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It is a matter of RIGHTS for adolescent girls
Introduction to International Human Rights

- The concepts of humanitarian intervention, self-determination, and providing relief to the wounded and other victims of armed conflicts can be viewed as the roots of human rights law.
- Modern international human rights law dates from World War II and its aftermath.
- The United Nations Charter, signed on June 26, 1945, sought to acknowledge the importance of human rights and established it as a matter of international concern.

The Standards

The human rights treaty system encompasses seven major treaties:

- the Convention on the Elimination of all forms of Racial Discrimination (in force 4 January 1969)
- the International Covenant on Civil and Political Rights (CCPR) (in force 23 March 1976)
- the International Covenant on Economic, Social and Cultural Rights (in force 23 March 1976)
- the Convention Against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment (in force 26 June 1987)
- the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (in force 1 July 2003)

The Treaty Bodies

The eight treaties are associated with eight treaty bodies which have the task of monitoring the implementation of treaty obligations. These are:

- the Committee on the Elimination of Racial Discrimination (CERD)
- the Human Rights Committee (HRC)
- the Committee on Economic, Social and Cultural Rights (CESCR)
the Committee Against Torture (CAT)
the Committee on the Rights of the Child (CRC)
the Committee on Migrant Workers (CMW).
the Committee on the Elimination of Discrimination Against Women (CEDAW).
the Committee on the Rights of Persons with Disabilities (CRPD)

The treaty bodies are composed of members who are elected by the states parties to each treaty.

**Other UN Monitoring Mechanisms**

**Charter based bodies**
- These derive their establishment from provisions contained in the Charter of the United Nations, and hold broad human rights mandates and address an unlimited audience.
- These include bodies such as the Human Rights Council and the UN Special Procedures.

**Regional bodies**
- American Declaration on Rights and Duties of Man (1948) and the American Convention on Human Rights (1978)
- European Charter on Human Rights (1953)
- ASEAN Human Rights Charter (draft)

**The National Level**
- The international system has had implications at the national level.
- A multitude of domestic legal systems have been affected by the treaties.
- The treaties form the basis of a significant number of the world’s bills of rights.
- There are also numerous instances of legal reform prompted by the treaties.
- Non-governmental organizations and national human rights institutions have invoked the treaty standards in relation to proposed government legislation and policies.
- Legislative committees have used treaty standards as reference points.
- The treaties have sometimes been incorporated into national law, had direct application through constitutional provisions to national law, and been used to interpret domestic law through judicial intervention.

**Rights implicated**
- Right to the highest attainable standard of health
- Right to non-discrimination
- Right to life
- Right to liberty and the right to security of the person
- Right to be free from inhuman and degrading treatment
- Right to education and information
WHO examples of laws, policies and practices

- Prohibiting access to information on legal abortion services, or failing to provide public information on the legal status of abortion;
- Requiring third-party authorization from one or more medical professionals or a hospital committee, court or police, parent or guardian or a woman’s partner or spouse;
- Restricting the range of health-care providers and facilities that can safely provide services, e.g. to physicians in inpatient facilities with sophisticated equipment;
- Failing to protect against abuse of conscientious objection by not ensuring referral;
- Requiring mandatory waiting periods;
- Censoring, withholding or intentionally misrepresenting health-related information;
- Restrictive interpretation of legal grounds.

WHO Recommendations

- Laws and policies on abortion should protect women’s health and their human rights.
- Regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed.
- An enabling environment is needed to ensure every woman who is legally eligible has ready access to safe abortion care. Policies should be geared towards:
  - respecting, protecting fulfilling human rights of women, to achieving positive health outcomes for women,
  - to providing good quality contraceptive information and services, and
  - to meeting the particular needs of poor women, adolescents, rape survivors and women living with HIV.

Annex 7

The process for developing the WHO guidelines for safe abortion second edition

Dr Nathalie Kapp, MD, MPH
Medical Officer
Department of Reproductive Health and Research
World Health Organization

Safe abortion guidance

- First evidence-based global guidance
- More than 20,000 copies distributed
- One of the most downloaded WHO documents
- Considerable new evidence since 2003

Guideline Development Process

1. Scoping the document
2. Setting up Guideline Development Group and External Review Group
3. Management of Conflicts of Interest
4. Formulation of the questions (PICO) and choice of the relevant outcomes
5. Evidence retrieval, assessment and synthesis (systematic review(s))
   - GRADE - evidence profile
6. Formulation of the recommendations (GRADE)
   - Including explicit consideration of:
     - Benefits and harms
     - Values and preferences
     - Resource use
7. Dissemination, implementation (adaptation)
8. Evaluation of impact
9. Plan for updating

Initial guideline approval
- After completion of 1 and 2
- With draft of 4
- With plan for 3, 5-9

Final guideline approval
- After completion of 6
- With plan for 7-9
Overview of guideline process

- Scoping of the guidelines
  - Identified priority topics internally from input from key external experts and organizations
    - Identified 35 issues and narrowed down to the top 18

Priority questions

- 3 are questions already addressed by our department:
  - Competencies to provide safe abortion services
  - Indicators of safe abortion services
  - Postabortion contraception
- 15 are clinical questions addressing the following issues:
  - Recommended methods for treatment of incomplete abortion
  - Recommended methods for induced surgical and medical abortion
  - Antibiotic use
  - Pain control
  - Ultrasound
  - Cervical preparation
  - Follow-up care

Overview for recommendations

- Each priority questions became the topic of a systematic review of the evidence
  - Evidence profiles were prepared based on recent systematic reviews
  - Rating of evidence and strength based on GRADE process
    - Annex 3

Technical Consultation

- Bring together global group of experts in the field, human rights lawyers and representatives/users of the guidelines
  - Review the evidence profiles
  - Advise on the interpretation of the evidence, with explicit consideration of the overall balance of risks and benefits
  - Formulate recommendations, taking into account diverse values and preferences
    - Decisions by consensus
  - Final recommendations in Annex 5

Clinical handbook for safe abortion care

- New document
  - Created due to feedback from the field
  - Intended to be practical, easy-to-follow guide for practitioners
    - Modelled after handbook for family planning
  - Reflects the clinical recommendations from the Technical and Policy Guidance
Next steps

Ongoing activities

- Distillation of new clinical recommendations into a journal article
  - Plan for publication in 2012
- Compilation of recommendations for guidelines for misoprostol
- Presentations on the guidance at large international conferences
  - FIGO, FIAPAC

Planned next steps

- After publication, dissemination workshops
  - In at least 3 WHO regions
  - Possibility of follow-up with strategic assessments and other country work
- Collaboration with partners
  - Major role in dissemination for the 2003 guidance
- Revision/ update in 4 years’ time
Preventing unsafe abortion to reduce maternal mortality

Report of the regional meeting held in Kathmandu, Nepal
Clinical Recommendations

Focus on:
- Pre abortion care
- Methods of Abortion
- Post abortion care
- Guidance for local adaptation

Pre-abortion care

- Determining the gestational age is a critical factor in selecting the most appropriate abortion method
- Bimanual pelvic examination, abdominal examination and recognition of symptoms of pregnancy are usually adequate
- Laboratory or ultrasound testing may also be used, if needed

Recommendations for care preceding induced abortion

- Ultrasound scanning
- Use of routine pre-abortion ultrasound scanning is not necessary
  *(Strength of recommendation: strong. Quality of evidence based on a randomized controlled trial and observational studies: very low)*

Prophylactic antibiotics

- All women having surgical abortion, regardless of their risk of pelvic inflammatory infection, should receive appropriate prophylactic antibiotics pre- or peri-operatively
  *(Strength of recommendation: strong. Quality of evidence based on randomized controlled trials: moderate)*
- For women having medical abortion, routine use of prophylactic antibiotics is not recommended
  *(Strength of recommendation: strong. Quality of evidence based on one observational trial: very low)*
Recommendations for care preceding induced abortion

Cervical preparation

- Prior to surgical abortion, cervical preparation is recommended for all women with a pregnancy over 12 to 14 weeks of gestation. Its use may be considered for women with a pregnancy of any gestational age
  (Strength of recommendation: strong. Quality of evidence based on randomized controlled trials: low)

Methods of cervical preparation

- Any one of these methods of cervical preparation before surgical abortion in the first trimester is recommended:
  - oral mifepristone 200 mg (24 to 48 hours in advance); or
  - misoprostol 400 μg administered sublingually, 2 to 3 hours prior to the procedure; or
  - misoprostol 400 μg administered vaginally 3 hours prior to the procedure; or
  - laminaria placed intracervically 6 to 24 hours prior to the procedure
  (Strength of recommendation: strong. Quality of evidence based on randomized controlled trials: low to moderate)

- All women undergoing dilatation and evacuation (D&E) with a pregnancy over 14 weeks of gestation should receive cervical preparation prior to the procedure
  (Strength of recommendation: strong. Quality of the evidence based on randomized controlled trials: low to moderate)

- The recommended methods of cervical preparation prior to dilatation and evacuation (D&E) after 14 weeks of gestation are osmotic dilators or misoprostol
  (Strength of recommendation: strong. Quality of evidence based on randomized controlled trials: moderate)

Recommended methods for surgical abortion

- Vacuum aspiration is the recommended technique of surgical abortion for pregnancies of up to 12 to 14 weeks of gestation
- The procedure should not be routinely completed by sharp curettage
- Dilatation and sharp curettage (D&C), if still practiced, should be replaced by vacuum aspiration
  (Strength of recommendation: strong. Quality of evidence based on randomized controlled trials: low to moderate)

Recommended methods for medical abortion

- The recommended method for medical abortion is mifepristone followed by misoprostol
- For pregnancies of gestational age up to 9 weeks (63 days)
- The recommended method for medical abortion is mifepristone followed 1 to 2 days later by misoprostol
  (Strength of recommendation: strong. Quality of evidence based on randomized controlled trials: moderate)
Dosages and routes of administration for mifepristone followed by misoprostol

- Mifepristone should always be administered orally. The recommended dose is 200 mg
- Administration of misoprostol is recommended 1 to 2 days (24 to 48 hours) following ingestion of mifepristone
  - For vaginal, buccal or sublingual routes, recommended dose of misoprostol is 800 μg
  - For oral administration, the recommended dose of misoprostol is 400 μg
  - With gestations up to 7 weeks (49 days) misoprostol may be administered by vaginal, buccal, sublingual or oral routes. After 7 weeks of gestation, oral administration of misoprostol should not be used
  - With gestations up to 9 weeks (63 days) misoprostol can be administered by vaginal, buccal or sublingual routes

For pregnancies of gestational age between 9 and 12 weeks (63–84 days)

- The recommended method for medical abortion is 200 mg mifepristone administered orally followed 36 to 48 hours later by 800 μg misoprostol administered vaginally
- Subsequent misoprostol doses should be 400 μg, administered either vaginally or sublingually, every 3 hours up to four further doses, until expulsion of the products of conception
  (Strength of recommendation: weak. Quality of evidence based on one randomized controlled trial and one observational study: low)

For pregnancies of gestational age over 12 weeks (84 days)

- The recommended method for medical abortion is 200 mg mifepristone administered orally followed 36 to 48 hours later by repeated doses of misoprostol
  (Strength of recommendation: strong. Quality of evidence based on randomized controlled trials: low to moderate)
  - With gestations between 12 and 24 weeks, the initial misoprostol dose following oral mifepristone administration may be either 800 μg administered vaginally or 400 μg administered orally
  - Subsequent misoprostol doses should be 400 μg, administered either vaginally or sublingually, every 3 hours up to four further doses
  - For pregnancies beyond 24 weeks, the dose of misoprostol should be reduced, due to the greater sensitivity of the uterus to prostaglandins, but the lack of clinical studies precludes specific dosing recommendations
Medical Abortion Using Mifepristone

Up to 7 weeks (49 days)
- Mifepristone 200 mg Oral
- Wait 24-48 hours
- Misoprostol 800 mcg Vaginal OR Buccal OR Sublingual

7-9 weeks (49-63 days)
- Mifepristone 200 mg Oral
- Wait 24-48 hours
- Misoprostol 400 mcg Oral
- Misoprostol 800 mcg Vaginal OR Buccal OR Sublingual

9-12 weeks (63-84 days)
- Mifepristone 200 mg Oral
- Wait 36-48 hours
- Misoprostol 800 mcg Vaginal

12-24 weeks
- Mifepristone 200 mg Oral
- Wait 36-48 hours
- Misoprostol 800 mcg Vaginal
- Misoprostol 400 mcg Oral
- Reduced dose of misoprostol* repeated until expulsion

24+ weeks
- Mifepristone 200 mg Oral
- Wait 36-48 hours

Lack of clinical studies prohibit specific dosing recommendations

** Consider feticidal agent for 20+ week gestations

RED boxes should take place in a health facility.
**Recommended methods for medical abortion - Where mifepristone is not available**

- For pregnancies of gestational age up to 12 weeks (84 days)
- The recommended method of medical abortion is 800 μg of misoprostol administered by vaginal or sub-lingual routes
- Up to three repeat doses of 800 μg can be administered at intervals of at least 3 hours, but for no longer than 12 hours
  
  *(Strength of recommendation: strong. Quality of evidence based on one randomized controlled trial: high)*

**For pregnancies of gestational age over 12 weeks (84 days)**

- The recommended method of medical abortion is 400 μg of misoprostol administered vaginally or sub-lingually, repeated every 3 hours for up to five doses
  
  *(Strength of recommendation: strong. Quality of evidence based on one randomized controlled trial: low to moderate)*

- For pregnancies beyond 24 weeks, the dose of misoprostol should be reduced, due to the greater sensitivity of the uterus to prostaglandins, but the lack of clinical studies precludes specific dosing recommendations

**Medical Abortion using Misoprostol only**

RED boxes should take place in a health facility.

* Lack of clinical studies prohibit specific dosing recommendations

** Consider feticidal agent for 20+ week gestations
Recommended methods of abortion for pregnancies of gestational age over 12 to 14 weeks

- Dilatation and evacuation (D&E) and medical methods (mifepristone and misoprostol; misoprostol alone) are both recommended methods for abortion for gestation over 12 to 14 weeks
- Facilities should offer at least one, and preferably both methods, if possible, depending on provider experience and the availability of training
  (Strength of recommendation: strong. Quality of evidence based on randomized controlled trials: low)

Recommendations for care post-abortion

Contraception

- Women may start hormonal contraception at the time of surgical abortion, or as early as the time of administration of the first pill of a medical abortion regimen
- Following medical abortion, an intrauterine device (IUD) may be inserted when it is reasonably certain that the woman is no longer pregnant
  (Strength of recommendation: strong. Quality of evidence based on randomized controlled trials: very low)

Pain management

- All women should be routinely offered pain medication (e.g. non-steroidal anti-inflammatory drugs) during both medical and surgical abortions
- General anaesthesia is not recommended routinely for vacuum aspiration abortion or dilatation and evacuation (D&E)
  (Strength of recommendation: strong. Quality of evidence based on randomized controlled trials: low)
- Remarks: Medication for pain management for both medical and surgical abortions should always be offered, and provided without delay to women who desire it
- In most cases, analgesics, local anaesthesia and/or conscious sedation supplemented by verbal reassurance are sufficient, although the need for pain management increases with gestational age

Follow-up

- There is no medical need for a routine follow-up visit following uncomplicated surgical abortion or medical abortion using mifepristone followed by misoprostol
- However, women should be advised that additional services are available to them if needed or desired
  (Strength of recommendation: strong. Quality of the evidence based on observational studies and indirect evidence: low)

Incomplete abortion

- If uterine size at the time of treatment is equivalent to a pregnancy of gestational age 13 weeks or less, either vacuum aspiration or treatment with misoprostol is recommended for women with incomplete abortion
- The recommended regimen of misoprostol is a single dose given either sublingually (400 μg) or orally (600 μg)
  (Strength of recommendation: strong. Quality of evidence based on randomized controlled trials: low)
**Recommendations for country adaptation**

- National standards and guidelines for safe abortion care should be evidence based and periodically updated, and should provide the necessary guidance to achieve equitable access to good-quality care
- New policy and programme interventions should reflect evidence-based best practices
- Complex service-delivery interventions require local evidence of feasibility and effectiveness through pilot-testing on a small scale prior to investing resources in scaling-up
- Training of abortion providers must ensure that they have the competencies to provide good-quality care in accordance with national standards and guidelines
- Ensuring good-quality abortion care requires ongoing supervision, quality assurance, monitoring and evaluation

**Summary – Key Recommendations for clinical practise**

- Vacuum aspiration is the recommended technique of surgical abortion for pregnancies of up to 12 to 14 weeks of gestation
- The procedure should not be routinely completed by sharp curettage
- Dilatation and sharp curettage (D&C), if still practised, should be replaced by vacuum aspiration
- Use of routine pre-abortion ultrasound scanning is not necessary
- All women having surgical abortion, regardless of their risk of pelvic inflammatory infection, should receive appropriate prophylactic antibiotics pre- or peri-operatively
- All women should be routinely offered pain medication (e.g. non-steroidal anti-inflammatory drugs) during both medical and surgical abortions
- General anaesthesia is not recommended routinely for vacuum aspiration abortion or dilatation and evacuation (D&E)
- For women having medical abortion, routine use of prophylactic antibiotics is not recommended
- Women may start hormonal contraception at the time of surgical abortion, or as early as the time of administration of the first pill of a medical abortion regimen
- Following medical abortion, an intrauterine device (IUD) may be inserted when it is reasonably certain that the woman is no longer pregnant
Preventing unsafe abortion to reduce maternal mortality

Report of the regional meeting held in Kathmandu, Nepal

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**Overview**

Positioning of abortion

- Integrate abortion into health system
- Abortion as a constellation of services
  - accurate but understandable information
  - Non directive counseling
  - Treatment of complications
  - Contraceptive information, services & referrals
- Involvement of other community professionals

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**Annex 9**

Safe Abortion: Technical and Policy Guidance for Health Systems

Chapter 3: An Overview

Mr Vinoj Manning
Country Director, Ipas - India

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“Rules are not necessarily sacred, principles are.” - Franklin D. Roosevelt
Contents of National Guidelines

- Types of abortion services
- Where and by whom
- Essential equipment, supplies
- Facility capabilities
- Referral mechanisms
- Informed and autonomous choice

Developing National Guidelines

- Involvement of stakeholders
- Evidence based
- Optimizing safety, good quality and accessibility
- Dissemination strategies
  - Public & Private
  - Multiple formats
- Routine review and updating

Equipping facilities & providers

“Abortion is not a favor for the medical profession to bestow but an obligation for them to perform.” - LESLIE CANNOLD, The Abortion Myth

Training as a Continuum

- **Pro-service training**: Based on skills and performance expectations for all appropriate cadres
- **In-service training**: On new, updated technologies. Address provider attitudes & beliefs
- **Post-training support**: Support to put skills into practice. Environment that ensures adequate drugs, equipment & professional development
Key Training Recommendations

- Comprehensive abortion care: safeguarding privacy and confidentiality, treating all women with dignity and respect
- Training on special needs of adolescents, rape survivors etc.
- New/updated procedure training; an opportunity for changing overall practice
- Training + equipped facilities + supportive environment

Distribution of health service providers (doctors, nurses and midwives)


Rural-urban distribution of health services providers

Data Source: (3,22).
Mid Level Providers

- Mid Level Providers → strategy to increase availability of abortion care
- Non-physicians: skills in pregnancy dating, diagnosis & trans cervical procedures
- Research evidence for safety and efficacy of mid level providers.

Program management

“A good idea is about 10% and implementation and hard work is 90 %”
- Guy Kawasaki

Services at Primary Level

- Vacuum Aspiration and Medical Abortion for Uterine Evacuation and incomplete abortion
- Inpatient care not required
  - pregnancies > 9 weeks for MA
  - MVA up to 14 weeks
- Referral linkages

Evaluation Indicators

Relating Health System Costs

Financing Abortion Care

“Having a liberal law is not enough unless it is backed up with adequate finance allocation to the health system” - Ms Sapna Pradhan Malla

Integrating Abortion Services

Managing Unsafe Abortion
Health System Financing

- Integrating abortion services
- Financing mechanisms → equitable access
- User fees = Women’s ability to pay
- Prevent informal charges
- Coverage under insurance plans

Key Stakeholders

The question should not be why do women not accept the service that we offer, but why do we not offer a service that women will accept?

-Mahmoud Fathalla
Annex 10.1

Evidence Based Standards and Guidelines on MR Service

Issues, Challenges, Barriers, Key Lessons

Dr Tapash Ranjan Das
Deputy Director
Directorate General of Family Planning
Bangladesh

Key Issues

- 29% of all births are unplanned (BDHS 2007)
- 45% of all unplanned pregnancies end in MR and back-alley abortion
- Estimated MR cases 90,000/year
- Under reporting of MR and Abortion
- MR Case rejection rate is high

Program Implementation Strategy

- GO-NGO Collaboration
- Government provide the training facility and logistic support (MVA Kit) for DGFP and NGOs
- NGO coordinate and conducted the training program of Government Service Providers

Background of National MR program

- 1974 GOB introduced MR service: MFSTC and CWFP
- 1978 Begin MR Training Program in 8 Medical college and two govt. District Hospitals
- 1979 National FP program included MR services through MVA to be available in all Government SDP

MR Program Implementation

Service Facilities:

- Government:
  - Medical College Hospitals
  - District Hospitals
  - Mother and Child Welfare Centre
  - Upazilla Health Complex -MCH-FP unit
  - UH&FWCs
- NGOs: RHSTEP, Marie Stopes Bangladesh, FPAB
• Private Clinics
• Training on MR:
  Doctor 9,864
  Paramedic 7,702
• Generalized training on Infection Prevention
• Annual Procurement of MVA Kit 10,000 (avg.)

**Challenges: MR Performance 2010**
• MIS reported cases 245,000 per year (avg.)
• Estimated cases 900,000 per year
  (Status includes all GO & NGO service delivery points)

**Challenges: Program Barriers**
• MR Rejection rate is high
  ■ First pregnancy
  ■ Repeated MR
  ■ Present with >10 week LMP
• Poor Monitoring and Supervision
• Provision of Post abortion and Post MR contraception not adequate
• Lack of Community Awareness activity
• Weak linkage with other RH services
• Side effect and complication management and referral
• Perceived conservative religious background
• Providers Attitude

**New Initiatives**
• Strengthening National MR Programme for Reduction of Maternal Mortality and Morbidity in Bangladesh - WHO as the Management Agency under RNE Challenge Fund
• Revitalization of MR service related committees (TAC; CCMRA, B)
• Generating rights-based demand creation in the community through the NGOs
• Creating enabling environment for the Professional bodies, Research Organizations, Development Partners
• Development of MR Service Delivery Guideline (GOB)

**Process of Development of National MR Guideline:**
• Formation of a working committee
• Hiring a National Consultant
• Literature review
• Disseminate the contents of Guideline in a workshop and incorporate the suggestions
• Taking approval from the TAC and also NTC
• Approval from the Director General of DGFP
Key Issues, Challenges and Barriers in Development of National MR Guideline:

- Determining the volume and contents of Guideline
  - How many pages
  - Whether the training curriculum be the part of this Guideline
- In which language: English, Bangla or both
- Addressing the legal aspects

Anticipated Challenges in Implementation of Guideline:
Planned to Publish the Guideline through a Launching Ceremony

Challenges:
- Awareness of the service provider about this Guideline
- Paramedical selection in NGO sector

New Initiatives
- Intervention study conducting for introduction of Abortion through Medication in Government facilities (ICDDR, B; MS, Population Council).
- Ipas Bangladesh working in integration of MR, PAC and FP services at DGHS and DGFP facilities.
- MVA Logistic Supply provision expand to other Health Care Service Delivery Departments.

Evaluation of MR Project
Impact on Maternal Mortality

Reduction of Maternal Mortality due to abortion:

- 5% in 2001 BMMS survey
- 1% in 2011 BMMS survey

Lessons learned

There should be:

- Strong coordination among the Government, NGOs, DPs, Professional bodies (OGSB), Academia
- Effective Community awareness activities
- Strong Linkage with other RH services, especially contraceptive services. Need to increase provision of post abortion and post MR contraception.
- Need Strong MIS
- Decentralize MR and PAC services by trained midlevel providers.
Annex 10.2

Establishing and Strengthening Abortion Services

Setting up, Service Delivery, Monitoring Drug and Equipment Availability

Dr Pritha Biswas
Medical Advisor
Marie Stopes International

Setting up and implementing service delivery - and ensuring adequate equipment and supplies is influenced by many and often overlapping, determinants

**Setting Up Services I**

- **Environment**
  - Liberal/Restrictive
- **Law Interpretation and Policy**
- **Socio-economic and Cultural Setting**
- **Drug Regulations**

**Setting Up Services II**

- **Program Design**
- **Stakeholder Involvement/commitment**
- **Sustainability, Projects/special Schemes/vouchers**
- **Baseline data HMIS**
- **Operations Research**

**Effective Pilots:**
- Scalable
- Locally appropriate
Setting Up Services III

- Assess
  Special needs, priorities,

- Program Design
- Budget Allocation

Integration with other services e.g. FP
Address the pregnancy continuum
Strong health systems

Service Delivery

- Harm
- Reduction
- Interventions

Monitoring

- Locally available
- Strong Management systems

- Drug registrations GMP certification
- Forecasting systems and training
- Monitoring Systems and tools
Best Practises

- Policy environment - liberal in Nepal, India and Vietnam. Restrictive in Pakistan and Bangladesh yet enabling....
- Policy, Guidelines and National Standards on Training and Service Delivery- India, Nepal. PAC Guidelines being developed in Afghanistan
- Medicines - include in national essential drugs list and MVA equipment in government standard equipment list e.g. Bhutan, Bangladesh (Miso)
- Drug Registration - Misoprostol registered for PPH in Pakistan, Bangladesh, Nepal and India. Afghanistan - pilot on Misoprostol for PPH proposed

Challenges

- Interpretation of the law - fairly liberal in Pakistan and Malaysia
- Restrictive environments lead to exploitation and stigma - safe services for rich and unsafe abortions for the poor and vulnerable (unmarried girls) e.g. Sri Lanka, Indonesia etc
- Outdated practises e.g. D&C, hysterotomy in restrictive settings
- Lack of awareness e.g. India MTP vs PCPNDT Acts reduce access to second trimester services
- Updating Policy, Guidelines and Standards in line with international best practise – ongoing in Cambodia
- Poor second trimester access in the region - lack of policy and/or implementation
- Poor forecasting and inadequate budget allocation leads to stockouts – e.g. pregnancy test kit stock-outs in India affecting access to early abortion
- Drug registration e.g. Misoprostol not registered for PPH in Sri Lanka

Restrictive Settings

- Advocate for change in law and policy and increase awareness about interpretation of the law, approved providers and services involving important stakeholders e.g. local professional bodies (FIGO)
- Community activities that promote women’s rights and decision making, reduce stigma
- Provide PAC – treat abortion complications, provide counselling and contraception
- Develop PAC Policy, Guidelines, Standards
- PAC training standards, PAC training, PAC supplies locally available
- Register Misoprostol for AT LEAST ONE indication
- Have strong MIS that informs program

YOU CAN DO A LOT TO REDUCE HARM ....

Impossibilities are possibilities that have not yet been attempted...
Preventing unsafe abortion to reduce maternal mortality

Report of the regional meeting held in Kathmandu, Nepal
Skilled provider: Accessible services
1. Curriculum Development
2. Competency Based
3. Pre / In service Training
4. Assessment & Quality Assurance

Designing curriculum
- Content / Skill
- Target trainee / participant (observers, analyzers, innovators)
- Methodology for delivery of content

Content & Methodology
- Standardized protocols on:
  - management of complications and their referral
  - Drug dosages, side effects
- Training aids (flip charts, hand outs, job aids)
- Role play scenarios, case studies

Best Practices
- Learner centered
- Based on adult learning principles
- Follow a structured way of sessions: objectives - session plan - handouts - time plan
- Involve objective analysis through Pre/post tests
- Pilot test – review - finalize

Use innovative approaches
- Mix of methods (blended learning)
- Didactic sessions: Online courses; Off site workshops; distance learning assignments
- Followed by clinical practicum and hands on training

Annex 10.3
Trainings: Lessons learnt & Challenges

Dr Sangeeta Batra
Senior Advisor, Health Systems
Ipas - India
Competency Based Trainings

Hands on sessions

Best Practices

Competency based trainings:

- Lots of hands on pelvic models & live cases, using checklists
- Viewing of procedure CD
- Fixed days schedule vs Fixed cases schedule
Integrated trainings

- Multiple related skills at one time
- Time saving for trainee and system
- Duplication in content avoided
- Comprehensive care package

But...........
- Unable to focus, feels lost
- Master of none

Challenges

- Addresses knowledge and skills but not attitudes
- Trainer:Trainee ratio
- Adequate time & caseload
- Skill loss if not immediately started

Pre service & In service Trainings

Preservice Training

- Catch them young
- Can train large numbers
- Easy transfer of knowledge
- Can address attitudes, beliefs
- Facilitates sensitivity
- Ready to start early

Inservice training

- Focused aspect/skill
- Customized, as per the need
- Immediate roll out of the services
- Availability of operational guidelines to ensure smooth implementation

Best practices

- Preservice is good opportunity for sensitization but less effective unless precisely defined
- Inservice is very focused, should be more comprehensive.
- Sequenced interventions are more effective than single interventions.
- Repeated exposures give better outcome
Challenges

<table>
<thead>
<tr>
<th>Pre service</th>
<th>In service</th>
</tr>
</thead>
<tbody>
<tr>
<td>● More generic topics covered</td>
<td>● Too focused. Comprehensiveness lost</td>
</tr>
<tr>
<td>● Not of immediate use, forgotten over time</td>
<td>● Cant be practiced if not logistically supported</td>
</tr>
<tr>
<td>● Waste of effort if the specialty is changed later</td>
<td>● Limited centers</td>
</tr>
<tr>
<td></td>
<td>● Out of compulsion participation</td>
</tr>
</tbody>
</table>

Assessment & Quality Assurance

Quality Assurance

● Objective is not just maintaining existing quality of training but make it an evolving process and changing continuously as per the need and feedback

When to Assess

![Diagram showing when to assess](image)

Best Practices

● Core group with stakeholders define, and then assess quality aspects
● QA Monitoring visits by higher authorities
● Link trainings to operationalization of services
● Periodic refresher workshops for trainers and providers

Challenges

● Focus is on activities’ roll out and quality takes a back seat
● Few known & understandable facts:
  ■ Overworked trainers
  ■ Trainers attrition. Capacity building process starts from scratch
  ■ Multiple trainings, at one time
  ■ Changing trainers’ attitudes and bias
Can access to safe abortion services be extended to rural women in Nepal by introducing medical abortion?

Can access to safe abortion services be extended to the community level?

2008: Gynuity study found 91% success rate of medical abortion (MA) and high client acceptability

2008-09: Pilot project to determine safety and feasibility of adding MA abortion services to public sector and NGO programs

- 86 providers (doctors and nurses) trained
- 32 sites in 6 districts
- 1718 women underwent MA
  - illiterate: 19%
  - disadvantaged castes: 37%

Success Rate

- MVA used: 3.7%
- MA only: 96.3%
- N = 1718

“Decentralizing abortion services to primary level”

Dr Indira Basnett
Country Director
Ipas - Nepal
MA Scale-Up Strategy-2009

- Train and equip all SAS providers and listed sites to offer MA - rural facilities are a priority
- Train female community health volunteers (FCHVs) for increasing awareness on safe MA services
- Move beyond existing SAS sites (e.g. to Primary Health Care Centers and Health Posts)
- Expand safe abortion care to poor, underserved women in inaccessible areas by training Auxiliary Nurse Midwives (ANMs)

WHO study

The provision of medical abortion up to 9 weeks gestation by MLPs and doctors was similar in safety and effectiveness

Where permitted MLPs can provide safe, low technology medical abortion services for women independently from doctors (The Lancet Volume 377, issue 97772, page 1155-161, 2 April 2011)

Interventions Focused to Increase Availability, Accessibility and Quality of MA Services at HPs
Quality Assurance Approaches

- Supportive Health Facility In Charges
  - MA site has minimum requirements
  - Managerial and administrative support
- Clinical coaching/mentoring by Clinical Mentors
- Supportive Public Health Nurses
  - Supervision/Monitoring
  - Ensure logistic supply
- Timely referral from FCHVs
  - Counseling/referring women with unwanted pregnancy

Supportive Supervision

- Blended training approach
- Each MA provider supported by a team (clinical mentor, public health nurse and facility In-charge)
- On an average one trained MA provider receive 2 in person visit and 3-4 telephone calls by any of the above
- Providers networking meeting
while providing medical abortion service there will be need of technical support. While working many obstacles come in front and it is not possible to learn all those things during the training. Therefore, to solve these unpredictable circumstances I need on site technical support and suggestions....

- ANM (SBA) from Dhading

**ANMs for MA quality service**

“The service is very close-by and I didn’t need to travel by vehicle to reach to the district hospital. It saved my money and time. Also no one in my village knew about my case, it was kept confidential. The nurse provided me with the tablets, I used them, and it just felt like a having normal menstrual period.”

- MA client

**ANMs & MA results (n=106)**

89% of trained ANMs were providing MA services

6,056 women received MA services with 100% receiving pain management and 88% receiving postabortion contraception

98% of clients reported being very/mostly satisfied with services

FY11-12 trained 106 ANMS as MA only provider
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

Figure 1. Main reason for non-performance in the last month as reported during most recent contact among 9 non-performing ANMs in NEPAL (cumulative for the period July 2011 – June 2012)

Key Issues

- Clinical skills: IUCD insertion, uterine size assessment
- IP practices: decontamination
- Logistics: supply of co-packaged drugs, IP supplies
- Counseling quality: privacy, responsive to the needs
- Recording reporting: logbook, client personal form
- Use of Job aids: protocol for complications management
- Post MA contraceptive methods
- Referral mechanism
- Provider support team (In-charges, PHN, and clinical mentors)
- Availability of MA drugs OTC
- Demand side: stigma, low level of awareness, cost

Source: Logbook

Logbook data from providers (ANMs) trained between July 1, 2011 and December 31, 2011 were included in Figure
Preventing unsafe abortion to reduce maternal mortality

Report of the regional meeting held in Kathmandu, Nepal
Annex 11.1

Group 1 Report:
Evidence based standards and guidelines

National Guidelines

<table>
<thead>
<tr>
<th>Country</th>
<th>Guidelines</th>
<th>Updated when</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>Yes</td>
<td>2010</td>
</tr>
<tr>
<td>Nepal</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Pakistan</td>
<td>No</td>
<td>PAC yes</td>
</tr>
<tr>
<td>Srilanka</td>
<td>Yes</td>
<td>PAC yes</td>
</tr>
<tr>
<td>Maldives</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>No</td>
<td>PAC yes</td>
</tr>
</tbody>
</table>

Challenges

- **Nepal**
  - Non availability of Appropriate service provider at PHC
  - Access to referral hospitals
  - Ability to change Non EB guidelines to current guidelines
- **Malaysia**
  - Not recognized as abortions
  - No guidelines from Govt
  - Imposing rule on ambulatory care which will curb abortion services
- **Srilanka**
  - Abortion services not allowed
  - PAC guidelines available
  - No Medical abortion services
  - VA services only for incomplete abortions preferred in PVT hospitals
  - In the process of legalizing abortions for rape
- **Indonesia**
  - PAC guidelines available
  - Abortion services not available
  - No guidelines from GOVT
  - Medical abortion drugs not available
- **India**
  - Do not mix sex selected abortions with safe abortion services

Suggestions to Challenges

- Incorporate WHO guidelines in respective countries
- Implementation to guidelines with the help of civil society organizations
- Educate legal & community stake holders
Annex 11.2

Group 2 Report:
Service delivery, setting up, monitoring, equipment and drug availability

The need for a protection (legal) scheme in restrictive settings for the provider, clinic and client
Gives confidence to providers to provide services need for doctors to know the law and policy
Adverse event management procedures in place.

Community awareness BCC/LEC – Demand generation activities is an important aspect of
Service delivery. Knowledge when one can get a service is ‘x’.

Need for a participating approach (addressing public-private partnerships) - key to high quality services.

Accessibility and affordability of services especially for poor and vulnerable group is an issue since
our countries have large proportions of these populations.

It is important to understand where clients are currently seeking services – need to study data and identify stakeholders to position services.

NGOs cannot regulate service provision by pharmacies but can help regulate, reduce harm and link to safe services.

Training is key to ensure service delivery e.g. in Cambodia MMA is allowed but not provided due to lack of training.

An important aspect of service delivery is to avoid exploitation of women both in accessing services and overenthusiastic surgical intervention of clients taking medical abortion.

Continuity of services – Important to have a logistic system to ensure constant supply of high quality drugs and equipment with no stock outs.

Need for a strong referral systems – both in-bound (through strong community mobilization and demand generation) and out-bound (to higher centres for complications and follow up of referral cases and a minimum of referrals in case of conscientious objection.

Need for clear guidelines addressing the need of vulnerable populations (especially Adolescents in Bangladesh)

Integration of services: While integration is important, it is also difficult to understand and having a common definition is a challenge. Need to ensure that integration is both at the level of training and service delivery (which is more important and challenging)
While thinking about service delivery it is important to appreciate the varied settings of the countries in the region and some settings (e.g. Sri Lanka) may need a strong tailor made approach to advocacy as part of starting service delivery.

Health financing models: Need to understand that financial barriers are still significant and can increase vulnerability. Need to identify various strategies to overcome them. Some examples include the following:

- Inclusion of benefits for abortion under the Maternity benefit schemes in the region
- Indonesia: Inclusion of Financing of all clinical services for pregnant women
- Bangladesh: Demand side financing for women to access services without barriers
- Cambodia: Voucher scheme in Cambodia in communities to expand access to safe abortion services
- No -refusal policy of IPPF Member affiliate clinics to clients seeking safe abortion services

Need to define, understand and agree upon what constitutes as a misuse / repeated use of over the counter medical abortion services – this needs to be educated to policy makers and program managers to ensure that we balance the right of the women to receive services with safety and quality of services.

Ensuring Quality of care of Safe abortion services is a vital part of monitoring these services. Address stigma and discrimination and promote awareness to ensure that services are safe and rights based.
Annex 11.3

Group 3 Report:
Training, Pre/In service, competency based, curricula, assessment and quality assurance

Selection and preparation of training

- Training site identification
  - Proper volunteer trainers.
  - Case load.
  - TOT prior to the training.
  - Training materials provided to the trainers.
  - Pre preparation is necessary for the training and also need to have a checklist.

Selection of participants

- Proper nomination of trainee
- The service site is

During training

- Pretest and post test for the trainees. Cent percent competency base is required prior to providing the certificate.
- Number of participants.
- 1 trainer can handle 7-8 trainees. Role of the trainers in clinical training is vital.

During training contd..

- Quality of training need to be ensured in all the training centers. So need to monitor the quality of the training with the help of the checklist.
- The IP need to be considered from all level of cadres and need to be addressed seperately.
- Feedback in the training is essential

Post training follow up-

- Skills are in use after the training.
- Enabling environment is in place.
- Supportive supervision.
- Trainees are retained after the training.
- Mentoring after the training is required so as to give clinical support for the trainees.
Post training …

- Post training need to be support on the orientation to all the staff/ equipment/ infrastrucutre

Challenges

- Duration of the training is a challenge
- Resources are spent in the public sector but also need to focus in private sector who are not keen on training.
- Alternate method for the training need to be considered.
- Clinical trainers were not part of the theoretical trainers

Pre-service training

- Level of curriculum—Content
- Instead of didactic also need to use different methodology-Case study, Role play, CD
- Competency training need to be done for the midlevel and physicians

Curriculum

- Comprhensive (Counseling/FP/IP/Adolescent)

Other discussion

- QA should be done by senior provider
- Skill can also be assessed and updated in professional meetings and workshop-Can give additional points
- Building network amongst the trainees and trainers

Integration of training

- Need to have other HR related trainings integrated
- Need to ensure the trainers are trained and updated as the need for the integration
Decentralization in two prongs:

- Technology level
- Health facility level

The process started in 2008 with the study done by Gynuity found 91% success rate of medical abortion (MA) and high client acceptability. The study was done mainly in the urban areas in big hospitals so the government was not ready to start the program just on the basis of this study. So a pilot study was proposed to find the feasibility MA services in rural areas, service sites for the expansion of service. On the basis of success of the study a consultative meeting was held to scale up the MA service.

With the decentralization marginalized community is being served who is deprived of service. Intervention are done in two levels – community based and health facility level

Minimum requirement for the training of the provider was Auxiliary Mid-Wife (ANM) who are Skill Birth Attendant (SBA) trained – 5 days training for the selected sites and selected trainees. Monitoring and supervisory mechanism after the training:

- Public Health Nurses is the supervisor - ensure equipment and logistics management and monitoring visit is provided to every provider in the quarterly basis.
- A clinical mentor is assigned for 3 to 4 providers - provide all the clinical support required for the providers.

Eligibility criteria:

- Trained providers needs to be certified
- Sites should be listed

Post training: Major element to ensure quality and regularity in service

- supply of drugs
- clinical mentor - goes coach in their facilities

Every year networking meeting of providers is conducted to discuss the issues and challenges faced by the providers.

Service is tracked in monthly basis for each provider. In an average 2 to 3 person is served by a provider.

At present decentralized service available in 21 districts
Key Issues:

- Clients are asked to come through emergency service which does not hide the confidentiality
- More intervention required for unmarried youth
- Law does not specifically not mentioned abortion service should be free

Question/Answer:

1. Is 5 days training enough for ANMs? Yes, they have already attended 3 months SBA training and have been providing delivery service.

2. What is the education level of clinical mentor and what is their monitoring schedule? CAC provider or trainers are the mentors. One mentor takes care of 3 to 4 providers in a district, mentoring provided in need based, quarterly monitoring by PHN using standardized checklist.

3. Are Clinical mentors paid? Yes Ipas is supporting.

4. Is M-Health being used? Extensive use of mobile phone by providers, FCHV, clients – referral card given to the clients with the providers contact number.

5. What is the motivation for the providers? Post service training - supportive supervision, mentoring and monitoring, 3 weeks after the training PHN and central level staff go to the health post and inform in the larger group about the availability of the service. Protection from their supervisors. Abortion fee paid by the client – Rs. 500 for MA and Rs.1100 for MVA.

6. Is consent taken from client for the follow-up? Yes

7. Is there any incentive for the career given? Not at present but NHTC is planning.

FPAN:

FPAN also have decentralized clinics – expanding to community hospitals. Two hospitals piloting already conducted and was successful – specifically MA services – this year planned to expand to 10 community hospitals and next year to 80. FPAN is work as a supplementary to the government. Referral sites are linked to these community hospitals

Country Situation:

India - First need to amend the law – can be taken up to PHC level. Monitoring will be significant challenge given the size of the country. Service needs to be regulated in private sector.

Decentralization to mid level providers may not be possible in few years– but law can be amend to screening the women for abortion and also identify complications, if any and referring them to the doctors.

Expand the law to provider services through Homeopathic and Ayurveda doctors which can be done immediately.

Operation research is required before amending the law

Cambodia: Abortion is legalized and requires more medical supervision

Pakistan: Value clarification of the service providers required
Timor Leste: Present law only allows to take care of post abortion care and emergency obs. care. Since 2005 Midwives and GP Doctors are allowed and decentralized up to health post level. If there is any complication transfer system up to district hospital or referral sites is in place. Most midwives are doing MVA. Service is fee they are nominated for diploma cost.

Nepal: Services should be integrated to make it more effective.

Indonesia: At present law allows only post abortion care. Post abortion training started in 2003. Trainers are a team of 1 doctor and 1 midwife, this team is regulated by government hospital. Recommendation: Facilitated by Dr. Tira Aswitama

1. Every country has to improve the policy barrier and expand the law on abortion.
2. Capacity building for ensuring quality of service.
3. Financial barrier creates difficulty in monitoring.
4. Value clarification of service providers on abortion – required to change the attitude of the service provider – religion needs to consider. High level providers do not want to decentralize mid level providers.
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal
Annex 12

Establishing Safe Abortion Service in Nepal

Dr Kiran Regmi
Ministry of Health and Population
Government of Nepal

Stepping forward through Abortion Laws, Policies, Procedural Order to Service Delivery

Outline

- Milestones of abortion
- Abortion laws
- Abortion polices
- Procedural order

- Expanding CAC service
- Future direction

Milestones of Abortion Events in Nepal

Milestones of Abortion Cases in Nepal
Abortion Law

<table>
<thead>
<tr>
<th>1964</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Abortion without woman’s consent (Service provider imprisoned)</td>
<td>If an abortion is carried out by a qualified and registered health worker by fulfilling the procedures as prescribed by the Government of Nepal, it shall not be deemed to be the offence of abortion, in the following circumstance:</td>
</tr>
<tr>
<td>1. Less than six month’s pregnancy: 2 Years</td>
<td>1. Fetus of up to 12 weeks with consent of the pregnant woman</td>
</tr>
<tr>
<td>2. More than six month’s pregnancy: 3 Years</td>
<td>2. Up to 18 weeks by rape /incest with consent of pregnant woman</td>
</tr>
<tr>
<td>B. Abortion with woman’s consent (Both woman and service provider imprisoned)</td>
<td>3. With consent of pregnant woman and advice of expert that physical/ mental health may be deteriorated or disabled child may be born</td>
</tr>
<tr>
<td>1. Less than six month’s pregnancy: 1 Year</td>
<td></td>
</tr>
<tr>
<td>2. More than six month’s pregnancy: 1.5 Years</td>
<td></td>
</tr>
</tbody>
</table>

Court Orders to Improve Women’s Access to Abortion

- Supreme Court ordered the Government to enact a comprehensive abortion law to guarantee that women have access to safe and affordable abortion services. (20.05.09)
- Under the court ruling, the government must set up a fund to cover the cost of abortion for poor and rural women; and invest enough resources to meet the demand for abortion services and to educate the public and health service providers of the existing abortion law

Abortion Policies 2002 > Features

- Concept of Comprehensive Abortion Care
- Assurance of skilled service providers
- Assurance of woman’s right
- Emphasis on Private and I/NGOs involvement
  - Information, Education, Communication and Feedback system establishment
- Organization of Abortion service planning, monitoring and coordination
- Development of Research activity

Abortion Policies 2002 > Institutional Arrangement

- Sub Health post- MA
- Health post/Primary Health centre/District Hospital/Zonal Hospital/Regional Hospital/Medical Colleges- Both MA and MVA

Safe Abortion Service Procedural Order 2003

- Clarifies the definition of abortion provider mentioned in Muluki Ain 2002 (Country Code)
- Lays down the criteria for listing of abortion service providers and service provision facilities
- Client consent
- Counseling
- Confidentiality
Preventing unsafe abortion to reduce maternal mortality
Report of the regional meeting held in Kathmandu, Nepal

- Post abortion family planning
- High quality service and appropriate technologies
- Information and services to prevent future unwanted pregnancies in local languages
- Reasonable and transparent service cost
- Internal and external resources mobilization
- Training of manpower
- Provision of pre service and in service training
- Provision of abortion quality assurance
- GoN is the main M&E agency
- Coordination and referral mechanism between abortion service providing institutions
- Increase access to safe abortion by increasing choices
- Involve I/NGOs and private to serve unreached and underserved areas and training activities with strict government supervision

Expanding CAC Service > Various Ways

- Involving midlevel health workers
- Providing 2nd trimester abortion service facility
- Providing MA facility
- Increasing trained human resource
- Rigorous monitoring and evaluation
- Ensuring adequate logistic and supplies

Expanding CAC Service > Various Ways > Service Provision by Midlevel Health Workers

- The Family Health Division of Nepal, Ministry of Health trained initial cohort of 96 nurses to provide 1st trimester CAC using MVA between September 2006 and July 2009.
- A study conducted in 2009 to evaluate the initial cohort of 96 nurses was encouraging
- All nurses achieved clinical competency
- 86% were providing CAC services at follow-up
- 62% were listed as CAC providers at follow-up

Reasons for non-performance of CAC services (n = 13)
Expanding CAC Service > Various Ways > Service Provision by Midlevel Health Workers > Assessment of Service Quality

Expanding CAC Service > Various Ways > Providing 2nd Trimester Abortion Facility

- 13% of women seeking abortion turned away as they were more than 12 weeks (A national facility based survey, 2006)
- A Strategic Plan for Second-Trimester Abortion based on global experience & evidence was developed
- It provided clinical standards for D&E & MA & specified facility & provider eligibility requirements (hospitals with emergency obstetric services and Ob/gyn or MDGP providers)
- The MOHP’s formal endorsement of the plan in April 2007 led implementation of second-trimester services

Expanding CAC Service > Various Ways > Providing MA Facility

- Government piloted MA in 32 sites of six rural districts (January-June 2009)
- MA scale up strategy was approved by the MoHP, 2009 November

Expanding CAC Service > Various Ways > Increasing Trained Human Resource

In service training

<table>
<thead>
<tr>
<th>Obs/MDGP</th>
<th>14 days 2nd trimester (D&amp;E/MA) training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 days 1st trimester integrated (MVA/MA) training</td>
</tr>
<tr>
<td>MBBS</td>
<td>10 days physicians’ CAC (MVA/MA) training</td>
</tr>
<tr>
<td>Nurses</td>
<td>14 days Nurses’ CAC (MVA/MA) training</td>
</tr>
<tr>
<td>Eligible criteria</td>
<td>Nursing council registration, one-year midwifery course in basic nursing education and have received in-service training on IUCD/PAC/SBA trained</td>
</tr>
<tr>
<td>SBAs</td>
<td>3 days MA only training to SBAs</td>
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</tbody>
</table>

On the Job training (30 days)

- MD/Obgyn residence
- MDGP residence/MBBS
Expanding CAC Service > Various Ways > Rigorous Monitoring and Evaluation

- Regular monthly data collection through HMIS system
  - HMIS-11 (CAC/PAC facility log book)
  - HMIS-32 (4 indicators) reported to FHD
- 4-5/monthly onsite Follow up & Supervision FHD
  - Ipas/Partners
- Need based Provider Progress Report
- Need based Provider skill assessment checklist

Expanding CAC Service > Various Ways > Ensuring Adequate Logistic and Supplies

Supplies by LMD

- MVA sets
- MA drugs for PHCs/HPs
- All CAC related equipments

Abortion Service Scenario in Nepal

<table>
<thead>
<tr>
<th>Variables</th>
<th>Sites</th>
<th>Provider</th>
<th>Cases</th>
<th>Duration</th>
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</thead>
<tbody>
<tr>
<td>1st trimester Abortion</td>
<td>1689</td>
<td>665</td>
<td>580273</td>
<td>2004 - June 2012</td>
</tr>
<tr>
<td>2nd trimester</td>
<td>19</td>
<td>46</td>
<td>1691</td>
<td>2007 - June 2012</td>
</tr>
<tr>
<td>MA</td>
<td>153</td>
<td>275</td>
<td>12418</td>
<td>2009 - June 2012</td>
</tr>
</tbody>
</table>

Source: HMIS

Provider base > Facilities

Distribution of safe abortion service facilities in Nepal
(Source TCIC Family Health Division Department of Health Service June, 2010)
Expanding CAC Service > Barriers

- Inadequate health facilities
- Inadequate health workers (0.4 doctors and 2.3 nurses per 10,000 population-source: MoHP)
- Lost trained providers
- Retention of clinical skills
- Political instability
- Difficult topography
- Cost barrier (11 USD for MVA, and 5.5 USD for MA)
- Limited access to a range of modern contraceptive methods
- Poor compliance to post abortion contraceptive methods
- Irregular supply of co-packaged MA drugs
- Low level of awareness

Future direction

- Provision of SBA and CAC training to MBBS doctors prior to their deployment
- Selection of participants using predefined criteria
- Training more midlevel service providers-ANM
- Provision of clinical coaching and mentoring at least once post three months training
- Update policy, guidelines, standards, manuals and procedures
Annex 13

Field Visit Safe Abortion Service Sites in Nepal

Dr Meera Thapa
National Programme Officer
World Health Organization
Nepal

…..Partnerships for Success
One of the unique aspects of this program is the continued partnerships of multiple. ..... 

Public - Private - NGO - Civil Society
Site visit

- Maternity Hospital
  - Referral level hospital
  - Training center for 1st and 2nd trimester abortion
  - Service site for 1st and 2nd trimester abortion
  - Service providing by Ob/gyn, MBBS, Staff Nurse
  - Both MVA and MA service available
- Khopasi PHCC, Kavre
  - Based in community
  - Service site for 1st trimester abortion
  - Service provided by MBBS, Staff Nurse, ANM
  - Both MVA and MA service available
- Naubise HP, Dhading
  - Based in community
  - Service site for 1st trimester abortion
  - Service provided by SBA trained ANM
  - Only MA services available

a Bungamati choice camp.

- Bungamati is a traditional village with about 12,000 population located in Latitpur district about 12 km away from Hotel Soaltee. Nepal has altogether 3,915 village development committee (VDCs).
- It's a centre point for 4 other VDS – Chhampi, Dukuchhap, Sainbu, Khokana
- There are one health post and two sub health posts in Bungamati.
- The population of Bungamati is homogeneous, however is dominant by indigenous Newar community.
- Has chosen this place at the request of the Bungamati VDC, as there are more than 300 depo-provera users who want to switch to long acting and permanent methods.

b Marie Stopes Centre, Chuchepati, Kathmandu:

- Established in June 1996
- Located at boundary of Kathmanadu Metropolitan city but it is accessible to many VDCs, slum population and factory workers
- Provides full range of FP, SA, ANC/PNC and pap smear services
- Equipped with 10 trained staff including a doctor
- Provided about 30 thousand safe abortion during 2005-2011, 13% of which is medical abortion
- Served about 58 thousand clients during 2005-2011, 35% of which are FP clients
- Post abortion FP clients is about 82%
C. Marie Stopes Centre, Satdobato:

- Established in July 2003
- Located at boundary of Lalitpur Sub-Municipality which is accessible to many VDCs and factory workers
- Provides full range of FP, SA, ANC/PNC and pap smear services
- Equipped with 10 trained staff including a doctor
- Provided about 12 thousand safe abortion during 2005-2011, 19% of which is medical abortion
- Served about 19 thousand clients during 2005-2011, 37% of which are FP clients
- Post abortion FP clients is about 61%

PSI strategies to support the MoHP Safe Abortion Efforts

- PSI/Nepal helps strengthen MA service delivery in the private sector through:
  - Provider Behavior Change to ensure effective counseling to MA client
  - Training, certification and listing private providers
  - Availability of safe MA drugs
  - Supportive IEC materials and job aids
  - Record keeping and reporting

Post Abortion Care

- Demand generation around SAS centers to inform public about availability of FP services
- Regularize the services for LARC in SAS centers
- Ensure providers counsel and provide Post Abortion FP services

1 Safe Abortion & Human Resources Development

- Site: FPAN Central Clinic, Pulchowk, Lalitpur
- National Training Centre recognized by National Health Training Centre (NHTC)
- FPAN also has two regional training centres: Sunsari of Eastern Region and Chitwan of Central Region
- Providing training for needs of FPAN as well as government and private sector
- Trainings on Safe abortion services (both MA+surgical) for doctors (10 days) and staff nurses (14 days) includes training on post-abortion contraceptive (IUD)
- MA training only: 3 days for doctors and 5 days for staff nurses
- 50 service providers trained per year (each batch includes 8-10 participants)
- Trainers need to have prior Clinical Training Skills (CTS) training of 7 days certified by NHTC
2 Safe Abortion & Reducing Need for repeated abortions

- Site: Banepa Family Health Clinic, Banepa, Kavre (28 km from Kathmandu)
- Pre-abortion Counseling to promote uptake of contraceptives
- Post-abortion Counseling to promote uptake of contraceptives
- Post-abortion follow ups
- IEC/BCC programs in community on safe abortions and family planning e.g. FPAN’s Reproductive Health Female Volunteers (RHFV) and government’s FCHV, contraceptives users groups, YIC
- IEC/BCC materials developed on safe abortions and family planning
- Strengthening Referral System through eCMIS system

3 Safe Abortion, Integrated SRH Services & Quality of Care (QoC)

- Site: Panchkhal Family Health Clinic, Kavre (35km from Kathmandu)
- Integrated Package of Essential Services (IPES) 8 components:
  1. Counseling: sexuality & relationships
  2. Contraceptives: Counseling, pills, condoms, injectables, IUD/Implants, EC or IUD
  3. Safe abortion services: Surgical/medical, pre-post abortion counselling
  4. RTI/STI: Treatment, lab test, condoms
  5. HIV: Pre & Post test counseling, lab test, condoms
  6. Gynecological services: Pelvic exam, breast exam, Pap or Cervical cancer screening
  7. Pre- and Post-natal care: ANC, PNC
  8. Sexual and GBV services: Screen, Referral for clinical, psychosocial and protection services
- Increasing Access through community awareness programs+IEC/BCC
- Providing High Quality Service supported by eCMIS (Clinical Management Information System)
- Reducing Stigma and discrimination
## Preventing unsafe abortion to reduce maternal mortality

Report of the regional meeting held in Kathmandu, Nepal

### Field Visit (Regional Meeting 17-20 Sept 2012)

<table>
<thead>
<tr>
<th>Name of the Organization</th>
<th>Area</th>
<th>Clinic</th>
<th>Theme</th>
<th>Responsible person from same organisations</th>
<th>Lunch Arrangement</th>
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</thead>
<tbody>
<tr>
<td>IPAS</td>
<td>Kathmandu</td>
<td>Maternity Hospital</td>
<td>Total SAS service MA, CAC, Second trimester abortion</td>
<td>Dr Deep Dangol, Dr Narimah Awin</td>
<td>Solutee</td>
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<tr>
<td>Khopasi</td>
<td>Khopasi</td>
<td>Khopasi PHC</td>
<td>PHC with CAC and MA service</td>
<td>Ms Madhavi Bajracharya, Dr Meera Thapa</td>
<td>Dhulikhel</td>
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<tr>
<td>Naubese</td>
<td>Naubese</td>
<td>PHC</td>
<td>PHC with MA service</td>
<td>Dr Indira Basnet, Mr Bimal</td>
<td>Lunch pack from Solutee</td>
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<td>FPAN</td>
<td>Pulchok</td>
<td>FPAN clinic Pulchok</td>
<td>CAC, MA and Family planning training center</td>
<td>Dr Bina Shrestha</td>
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<tr>
<td>Panchkhal</td>
<td>Panchkhal family Health Clinic</td>
<td>Integrated package of essential service (8 Components)</td>
<td>Dr Naveen Thapa, Dr Arvind Mathur</td>
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<td>Banepa</td>
<td>Banepa family Health Clinic</td>
<td>Family planning and CAC service</td>
<td>Dr Pramij Thapa, Ms Ritu Agarwal</td>
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<td>MSI</td>
<td>Kathmandu (Bungmati)</td>
<td>Bungmati Valley clinic MSI</td>
<td>Community center with FP and MA service</td>
<td>Mr Pratap Kr Acharya, Mrs Deepa</td>
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<td>Chabel</td>
<td>MSI Center Chuchepati</td>
<td>FP, SA, ANC/PNC and pap smear services</td>
<td>Mr Ganesh Kr Pokhrel</td>
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<td>Satdobato</td>
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<td>Ms Puspa Lamichane</td>
<td>Solutee</td>
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<td>PSI</td>
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<td>Madhyapur Hospital Pvt. Ltd. Madhyapur, Thimi, Bhaktapur &amp; Kirtipur Hospital, Kirtipur</td>
<td>MA service through private sector</td>
<td>Dr Farita Lama, Ms Bandana Pradhan</td>
<td>Bhaktapur</td>
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<td>Kavre</td>
<td>Satya Sai Poly Clinic &amp; Research Center Pvt. Ltd., Banepa, Kavre &amp; Dhulikhel PHC, Dhulikhel, Kavre</td>
<td>MA service through private sector</td>
<td>Dr Mandira Shrestha, Ms Paritra Tamrakar</td>
<td>Dhulikhel</td>
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</tbody>
</table>
Annex 14.1

Decentralization and scale up of abortion services through partnership

Ms Anu Kumar
Executive Vice President
Development, Communications, and Community Access, Ipas

Ipas Country Programs in Asia
- Vietnam 1994 - 2009
- India 2001 - present
- Nepal 2002 - present
- Cambodia 2006 - 2009
- Pakistan 2006 - present
- Bangladesh 2011 - present

Ipas strategies to promote safe abortion access in Asia
- Ipas role as catalyst and facilitator for integration of abortion care in health systems; expand CAC and appropriate technologies.
- Innovations in community access and BCC
- Research agenda to provide evidence-base for practice and policy.
- Partnerships with ob-gyn societies, MSI, PSI, IPPF member associations, women’s organizations, civil society and other networks.

CAC Model
Expanded Service Delivery Model

India: Accomplishments

- 11 States
- 118 training centers
- 5449 providers providing CAC services.
- 100,000 women receiving CAC services every year
- Member of the expert committee for Amendments to the MTP Act.
- GOI releases CAC guidelines
- Adaptation of Ipas resource material by the National Government
- Integration of CAC in State budget allocations
- Incorporation of program support and clinical mentoring

Areas being Strengthened for CAC in India

- Post training support to increase trainee effectiveness (clinical and program)
- Increasing local capacities for CAC awareness
- Evidence based research for strategic action
- Recent foray unexplored areas; ‘Youth’, ‘Stigma’ etc.
- Exploring different channels for community awareness
- Private sector data collection
- Networking CAC providers (CAC Connect)
- De-linking CAC and PCPNDT at the policy level
Expanding access in Nepal

- Integration with safe motherhood services key to increasing access in rural and remote areas
- Decentralizing services to lowest levels through midlevel providers, and expanding community access
- Importance of linking CAC and PAC with FP services
- Linking service access with community outreach
- Scale up based on evidence (MA pilot)

Nepal: Accomplishments

- 155 intervention sites in 16 districts providing CAC services with 257 providers providing CAC services.
- 8,198 women receiving CAC.
- 262 ANMs trained to provide MA services
- FCHVs trained in early pregnancy detection and referral
- Dojiya radio program about safe abortion aired in 75 districts

Building Capacity and Awareness of Safe MR in Bangladesh

- Introduce MR and PAC provision by nurses
- Review & update MR and PAC curriculum
- Improve community awareness of safe MR and FP services
- Support policy-level changes of improved PAC and MR service practices

Bangladesh: Accomplishments

- 2,566 FP services provided.
- 31 intervention sites established.
- 311 health workers trained.
- 2,790 UE services provided.
Building Local Capacity through TA with limited country presence in Pakistan

- Cost-effective, resource limited interventions are yielding steady growth and progress.
- National leadership and the active involvement of civil society and communities is the key to success.
- The collective focus is on promoting capacity-building and leveraging resources, both national and international, to achieve common goals.

Key Activities in Pakistan

- PAC Clinical skills training
- VCAT workshops
- Participation in conferences/events
- Facilitating policy and creating an enabling environment

Pakistan: Accomplishments

- 457 FP services provided.
- 40 intervention sites established.
- 82 health workers trained.
- 896 UE services provided.

Ipas Research in India

• Banerjee, Sushanta K., Kathryn L. Andersen, Rebecca M. Buchanan and Janarden Warvadekar. 2012. Woman-centered research on access to safe abortion services and implications for behavioral change communication interventions: A cross-sectional study of women in Bihar and Jharkhand, India. BMC Public Health 2012, 12: 175.

Ipas Research in Nepal


Ipas Research in Pakistan and Bangladesh


• Ipas and International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B). 2010. Preventing unsafe abortion in Jessore district. SMRC knowledge translation brief. Dhaka, Bangladesh: ICDDR, B.

• Benson, Janie, Kathryn Andersen, and Ghazaleh Samandari. Reductions in abortion-related mortality following policy reform: Evidence from Romania, South Africa and Bangladesh. Reproductive Health 2011, 8: 39.


Committed to improving the lives of women in Asia
Preventing unsafe abortion to reduce maternal mortality

Report of the regional meeting held in Kathmandu, Nepal
Annex 14.2

Increasing Access to Abortion Services Through Advocacy and Service Delivery

Dr Karthik Srinivasan
Program Officer
International Planned Parenthood Federation

International Planned Parenthood Federation

- Federation of 152 Member Associations (MA’s) working in 172 countries across the world
- Promotes a rights based approach to Sexual and Reproductive health (SRH) service delivery
- Provides oversight through a Central Office in London, UK and 6 regional offices across the world
- The South Asia Regional office, located in New Delhi is the secretariat for 9 MA’s in 9 countries in the South Asia region

Member Associations in South Asia Region

IPPF’s Change Goals

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<thead>
<tr>
<th>UNITE</th>
<th>Sexual rights are universally upheld as human rights</th>
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<tbody>
<tr>
<td>DELIVER</td>
<td>Access for all to reduce unmet need by doubling IPPF’s services</td>
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<tr>
<td>PERFORM</td>
<td>An effective federation that is relevant and accountable</td>
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</table>
Framework of 5 A’s as thematic focus

- Safe Abortion including post abortion care
- Access to SRH services
- Adolescents and young people
- HIV/AIDS
- Advocacy for rights and services

Increasing Access to Safe Abortion

Advocacy for Policy & Practice change

Safe Comprehensive Abortion Services

Advocacy for Safe Abortion

Policy & Practice change

The ‘law and obstacles’ tool

- Explore and understand laws, regulations & extra-legal obstacles relating to abortion
- Identifies opportunities on increasing access to abortion can be undertaken in all countries
- Challenges the argument that “abortion is illegal” when it is not.
- The sheer number of obstacles in place often motivates urgent action to be take
- Identifies barriers even in settings that are perceived as liberal
Policy Advocacy in South Asia

- Engaging parliamentarians to support SRH services including safe abortions
- Key regional and in-country partner of FIGO initiative to reduce unsafe abortions in the region
- Support for law reform and policy approvals on access to safe abortion (FPAN, FPASL)
- Registration of medical abortion drugs (FPASL)
- Authorizing mid-level providers to perform safe abortion services (FPAP, FPAN)

Practice Change Advocacy in South Asia

- IPPF - MA’s are certified training institutions on comprehensive abortion services (FPAI, FPAN)
- MA’s work on updating safe abortion and post abortion care protocols/guidelines (FPAP, AFGA, FPASL)
- Increase access to medication abortion services (FPAI, FPAN, FPAP)
- Increasing access to second trimester abortion services transitioning to D&E and medical abortion methods

Safe Abortion Service delivery

Comprehensive Abortion Care Guidelines and tools for Clinics

- Practical tips in line with WHO guidance on how to set up and run clinics
- Ensure infection prevention
- Manage logistics
- Monitor quality of care
- Assess clinic performance
- Use data for programme management
Safe Abortion service Delivery – South Asia

- Annual increase of 16% in abortion procedures
- Proportion of medical abortion doubled annually
- Increased focus on treatment of incomplete abortions
- Post-abortion contraception rates between 73 – 97%

IPPF Best practices - Safe abortion services

- Reaching the poor and the marginalized
  - “No refusal policy”
  - Subsidized and free services
  - Extending clinic opening hours
- Strengthen partnerships for access to disadvantaged individuals
  - Youth networks, PLHIV groups, Pharmacists
- Closer to communities through a range of service delivery points – hospitals, clinics, satellite centres
- Integrated with a wide range of SRH services
  - Contraceptive, HIV/STI, Cervical cancer screening, Sexual and Gender based Violence services

Challenges & Opportunities

<table>
<thead>
<tr>
<th>Advocacy</th>
<th>Service Delivery</th>
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<tr>
<td>• Increasing conservatism leading to restrictions on the right to safe abortion for women</td>
<td>• High proportion of abortions in the region are still unsafe</td>
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<td>• Opportunities for task sharing and task shifting in the region</td>
<td>• Need for trained Human resource and infrastructure</td>
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<tr>
<td>• Increasing the number of legal indications for safe abortion</td>
<td>• Drug quality assurance for medication abortion</td>
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<td>• Equipment and Supply chain security</td>
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Annex 14.3

Saving Lives and Delivering Choice:
Working with governments to provide safe abortion and post abortion care services in Asia

Ms Bethan Cobley
Policy Advisor
Marie Stopes International

1. Overview of MSI

2. Examples of partnership

3. MSI and national action plans

Saving Lives, Delivering Choice, Empowering Women

MSI is one of the world’s largest family planning organisations, each year we serve more than 7 million people in 42 countries across Asia, Africa, Latin America and Europe.

Our vision : a world in which every birth is wanted
Our mission : children by choice, not chance

Established in 1976, for over 30 years women have trusted MSI to provide them with a full range of quality, reproductive health choices – including delivering safe abortion.

Key Principles

Commitment to saving lives - MSI exists to bring family planning and reproductive healthcare to the world’s poorest and most vulnerable women and men.

Partnership - working closely with governments, existing private healthcare providers and other agencies to deliver services, strengthen national health systems, provide training, improve health policies, and share expertise

Educating and empowering women to make their own choices.

Reaching underserved communities - for example to refugees or those affected by disasters.

Innovations - for example our social franchising, insurance and voucher schemes
In 2011, we:

- Operated 600 clinics, 300 outreach teams and 1700 social franchises - 98% of our impact was in low income countries
- Prevented 1.65 million unsafe abortions
- Supplied 11 million people with contraception
- Prevented 11,000 deaths
- Prevented 4.5 million unintended pregnancies
- Saved families and the healthcare system an estimated $190 million

- In Asia we currently have country programmes in:
  - Afghanistan
  - Papua New Guinea
  - Bangladesh
  - Philippines
  - Cambodia
  - Myanmar
  - China
  - Nepal
  - India
  - Timor-Leste
  - Pakistan
  - Vietnam

- Where legal, alongside family planning services we are expanding access to safe abortion, offering both surgical and medical abortion. Everywhere we operate we offer post abortion care.
- For women who cannot reach our clinics we use outreach teams and community based health educators.
- We aim to build sustainable local services so women aren’t driven to unsafe providers.

Example 1 - Partnering with governments to deliver quality services at scale (Nepal)

- MSI are one of the leading providers safe abortion services in Nepal. In 2011 we performed more than 75% of all safe abortions in Nepal.
- Safe abortion services are delivered through 52 clinics in 41 districts.
- MSI’s training centre in Lalitpur is certified by the Government to provide training in comprehensive abortion care and family planning to MSI and government service providers.
- MSI provides family planning services through clinics, social marketing and through MSI and government mobile clinics.
- MSI works in close collaboration with the government to provide services, to conduct studies, to develop guidelines and to improve overall quality of services.

Results

- Dramatic decrease in deaths from unsafe abortion
- Effective, quality services with robust monitoring and evaluation
- The Government of Nepal has acknowledged MSI’s contribution in reducing the maternal deaths and increasing the contraceptive prevalence rate
MSI has been contracted by Governments to deliver services across Africa, the UK and in India and Bangladesh:

Contracting services can improve access and coverage of services, improve quality, deliver accessible and culturally sensitive services and improve impact and reach of public sector health expenditure.

Example 2 – Increasing Access through Public Sector Social Franchising (Vietnam)

Social franchising groups existing service providers under a shared brand to form a network of practitioners offering standardised services

- The Vietnam government wanted to strengthen local level provision through commune health stations which have high coverage but offer poor services.
- MSI worked with provincial health departments to establish a franchise network of 38 commune health stations, each serving 2000 families.
- Extensive training carried out by 25 provincial master trainers.
- Branding developed with community consultation - emphasising empowerment of women and a high quality client centered focus.
- Franchised centres were all refurbished and refitted - marketed extensively through road shows, local newspapers, TV and website - each centre has 2 brand ambassadors.
- Ongoing technical advice, support and monitoring provided by MSI.

Results

- FP and SA services delivered quadrupled
- Strengthened and increased use of commune health stations
- Positive feedback from clients – long term changes in women’s health seeking behaviour

Lessons Learnt

- Franchise principles can be applied to improve public sector
- Pre-test all branding, social marketing and communications
- Ensure quality of care through ongoing monitoring and evaluation – refresher courses for staff
Social franchising can increase use of existing services, reach underserved and marginalised communities, improve knowledge and practices of service providers, expand number of services available and give clients greater access to referral networks

Example 3 – Providing Technical Assistance on Policies and Protocols (Afghanistan)

In Afghanistan 236,000 women undergo an incomplete abortion each year and safe abortion is very restricted. Post Abortion Care was recently legalised but the lack of practical information and training limited PAC services which are still perceived to be illegal:

- MSI advised and worked closely with the Ministry of Public Health to develop guidelines, chairing and convening a working group of technical advisors.
- In August the Government approved the country’s first PAC Guidelines.
- The guidelines will enable women to access emergency treatment, post abortion family planning, counselling, and HIV testing and referral. They contain practical measures to empower women through awareness raising and community mobilisation.
- As one of the largest providers of family planning in Afghanistan MSI is now working with the government to implement the guidelines to bring PAC within reach of all women in Afghanistan - through training, education, advocacy and the provision of equipment and drugs.

MSI and national action plans...

- A cost effective, efficient and reliable way to provide accessible, safe services - through public, private or existing MSI outlets. Assure quality and enable governments to take ownership of the private sector.
- Where legal to catalyse providers to provide medical abortion. Rapid scale up not limited to public clinics.
- Expertise, capacity building and training. Sharing strategies, what works and new innovations.
- Creative and sustainable financing and cost recovery models (for example DFID and USAID are major partners and MSI are keen to leverage these funds to deliver effective services).
- Policy advice - legislation and guidelines (particularly on safe abortion, task sharing and drug registration)
Unsafe Abortion – A public health crisis

Every year:
- 22 million unsafe abortions
  - 47,000 women die
  - More than 5 million suffer serious injury

Every eight minutes:
- A woman dies due to complications from an unsafe abortion

Reducing deaths from unsafe abortion?

- Increasing access to safe abortion services within the legal framework of the countries
- Improving post-abortion care services
- Informing and educating women
- Increasing access to family planning

PSI’s Programs at a Glance
Safe Abortion/Post-Abortion Care Strategies

- **PARTNERSHIP** with governments to support national strategic priorities
- **DISTRIBUTION** of misoprostol to health facilities and pharmacies for post-abortion care.
- **PLACEMENT & DETAILING** of MA and/or Miso for safe abortion/post-abortion care.
- **TRAINING** providers in safe abortion/post-abortion care protocols including post-abortion family planning, and establishing referral networks.
- **EDUCATING** women about early detection of pregnancy, where to access family planning and safe abortion/post-abortion care if needed
- **REGISTRATION** of misoprostol for post-abortion care.
- **ADVOCACY** with governments to incorporate misoprostol as a standard protocol for PAC as per the WHO recommendation.

**PSI’s Approach**

**PSI’s Social Marketing Approach to Medication Abortion**

<table>
<thead>
<tr>
<th>MA Sales Achievement vs. LoP Projection</th>
<th>469,796 medication abortion packs sold since January 2011 in India, Nepal and Cambodia</th>
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</thead>
<tbody>
<tr>
<td>Nepal Achievement</td>
<td>61,977</td>
</tr>
<tr>
<td>Cambodia Achievement</td>
<td>165,630</td>
</tr>
<tr>
<td>India Achievement</td>
<td>210,189</td>
</tr>
</tbody>
</table>
Increasing Access to safe abortion services through MA

PSI works with private providers through Social Franchising
- India- 900
- Nepal- 630
- Cambodia- 250
- Pakistan- 440

Training on legal issues, drug protocols, complication management, facilitating registration of facilities

Increasing Access to safe abortion services: Working with Pharmacists

Improvement of dispensing behavior by orientation on
- The legalities
- Drug dosage
- Route of administration of drugs
- Linkages to certified providers.
- Information of toll free helplines

Post-abortion Care Strategies
- PSI works in 13 countries worldwide
- 3 countries in Asia region
  - Laos, Myanmar, Pakistan
  - Pakistan (Greenstar)- Social Franchise network of 7,000 private providers
- Training of providers in Early Pregnancy Bleeding Management (MVA)
- Monitoring & Quality assurance
- Reporting
- Pakistan – 2,035 MVA cases (Apr’ 11-Jul’12)

Community Awareness
- EDP mass media
- Interpersonal communication (IPC)
- Helpline
  - India: 18001200160
  - Cambodia: 012999124
  - Nepal: 4440 (mHealth)

Success Story
- Worked with MoH to register MA drug and include it in essential drug list - Cambodia, Nepal & India
- Conducted intensive medical detailing to providers and pharmacies to address provider attitudes, self efficacy, and social norms - Cambodia, Nepal & India
- Strengthened supply chain to public sector referral hospitals - **Cambodia, Nepal**
- Support for users through a hotline/helpline - **Cambodia, Pakistan & India**
- Recognition of private sector MA training by the MoHP - **Nepal**
- Improved dispensing knowledge and practice among pharmacies oriented by PSI - **Nepal, Cambodia & India**
- Regularization of LTM FP services in safe abortion sites in 20 districts - **Nepal**
- Registration of 137 sites for abortion services - **India**

**Medical Detailing Visits: Addressing provider attitudes, self-efficacy and social norms**

PSI/India developed a puzzle game, creative tools to communicate correct drug protocol
IEC

IEC materials are branded to associate safe abortion with the high quality product

Women are not dying because of diseases we cannot treat. They are dying because societies have yet to decide that their lives are worth saving.

- Dr Mahmoud Fathalla
Annex 15

Strategic Approach

Dr Arvind Mathur
Medical Officer
Making Pregnancy Safer
World Health Organization

The Strategic Approach to strengthening SRH policies and programmes

Focus, dynamics and context

Needs and perspectives; gender and human rights issues; stigma

People

SERVICES
System capacity to provide access; availability; good quality of care

TECHNOLOGIES
Availability; quality; cost; choices

Social, cultural, legal, political and economic contexts
Stage I Strategic Assessments

- Explore users’ needs and perspectives
- Examine service capacity
- Focus on the method mix
- Explore links to other reproductive health issues
- Emphasis on access, availability and quality of care

Stage I Strategic Assessments: Process

- Background paper synthesises existing knowledge
- Planning workshop
- Participatory process involving multiple stakeholders
- Use qualitative field methodologies
- Country ownership of process and results

Guided by strategic questions

- How to reduce unintended pregnancy?
- How to improve access to and availability of safe abortion care?
- How to improve the quality of abortion care?

Assessment Outcomes

- Recommendations for policy change or formulation
- Direct programme adaptation
- Stage II introductory research
- Identification of broader RH research agendas
- Stronger links between stakeholders
- Improved partner co-ordination

Stage II: Introducing and testing interventions on a small scale

-Focused on the recommendations and priorities established by the assessment
- Tests packages of interventions
-Continues to involve, in a participatory manner, a wide range of stakeholders

Stage III Scaling-up

- Focus on policy dialogue, planning and action for programme expansion utilizing the results of the assessment and the action research
- Stage III involves:
  - Dissemination of Stage II findings
  - Development of strategic plans for expansion
  - Scaling-up of service delivery innovations
  - Additional service delivery research
- Scaling-up needs to be considered from the initial stages
Key partners, roles, and relationships

- Political authority
- Ownership
- Leadership
- National standards

Member State

WHO

- Global health authority/credibility
- Evidence-based guidelines
- Technical support
- Political cover

Development Partner

NGO

- Civil society
- Accountability
- Local coordination
- Training
- Implementation

Adaptation of the Strategic Approach

Adaptation of the Strategic Approach to address other reproductive health issues including:

- Abortion
- STIs/RTIs
- Maternal and newborn health
- Adolescent reproductive health
- Comprehensive reproductive health services

Strategic Assessments on unintended pregnancy and abortion
Chronology of events and activities in Moldova

<table>
<thead>
<tr>
<th>Strategic assessment</th>
<th>Development of national standards, guidelines, training curricula</th>
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<tbody>
<tr>
<td>2005</td>
<td>2007</td>
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<td>2006</td>
<td>2008</td>
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<td>2009</td>
<td>2010</td>
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<td></td>
<td>Introduction of outpatient comprehensive abortion care</td>
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<td>Scaling-up outpatient care</td>
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</tbody>
</table>

Tools: WHO guidance on safe abortion

http://www.who.int/reproductive-health/publications/safe-abortion/index.html

Tools: WHO Strategic Approach


A question for the audience

What can WHO do to better facilitate use of its safe abortion guidance in countries?

Acknowledgements

Dr Ronnie Johnson, PhD
Department of Reproductive Health and Research

Dr Peter Fajans
Annex 16

Instructions for Group Work for Country Planning

1. Reflect and further identify barriers to access to safe abortion service and/or post-abortion care.

2. Develop plan of actions for improving access to and quality of such services (based on the legal framework of each country), including division of responsibilities among MoH, professional organization, relevant NGOs and other stakeholders.

3. Identify steps for adaptation, adoption and dissemination of the National Guidelines for Safe Abortion.

4. Identify necessary strategic information for programming in preventing and management of unsafe abortion and how to get such information.

5. **Identify 3-5 Key Priority Actions** at the country level.
**GROUP WORK on Country Action Plans**

The following framework can be used as a guide to steer the discussions and formulating framework for plan of action. This is only suggestive and you may add/delete as deemed necessary.

<table>
<thead>
<tr>
<th></th>
<th>Safe Abortion services</th>
<th>Access to Post Abortion Care especially post abortion contraceptives</th>
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<tr>
<td><strong>Current situation</strong></td>
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<td>Services available</td>
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<td>Access to services</td>
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<tr>
<td>Access to vulnerable population groups</td>
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<tr>
<td>Factors influencing access including socio-cultural determinants</td>
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<tr>
<td><strong>Legal and policy Environment</strong></td>
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<tr>
<td>Prioritization of abortion services and post abortion care in govt policies - initiatives taken and what more needs to be done</td>
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<tr>
<td>Authorization for service delivery to various cadres of workers</td>
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<td>Expanding services – need and strategy</td>
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<td><strong>Service delivery</strong></td>
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<td>Main service providers</td>
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<tr>
<td>Main methods</td>
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<td>Availability and use of standards and guidelines and whether they are in conformity with WHO guidance 2012</td>
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<tr>
<td>Training issues – need for expansion/revision</td>
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<tr>
<td>• Pre-Service Training for doctors and nurses</td>
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<tr>
<td>• In Service Training</td>
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<td>• Curriculum review and development issues</td>
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<td><strong>Counselling services</strong></td>
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<td><strong>Supply and logistics chain</strong></td>
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<td><strong>Supervisory mechanisms</strong></td>
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<tr>
<td><strong>Addressing Quality of care</strong></td>
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<td><strong>Monitoring and reporting</strong></td>
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<td><strong>Need for Advocacy and modus operandi</strong></td>
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<td><strong>Families and communities</strong></td>
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<td><strong>Policy level</strong></td>
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<tr>
<td><strong>Role of professional organizations, NGOs and other relevant stakeholders</strong></td>
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### Agenda

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<th>Registration</th>
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<tr>
<td><strong>Inaugural Session</strong></td>
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<tr>
<td>Lighting of lamp</td>
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<tr>
<td>Welcome remarks by WR and Message from the Regional Director, Dr. Samlee Plianbangchong</td>
</tr>
<tr>
<td>Opening remarks by Government of Nepal</td>
</tr>
<tr>
<td>Opening remarks, objectives of the meeting and appointment of chairpersons, co-chairpersons and Rapporteur</td>
</tr>
<tr>
<td>Remarks by RHR, HQ</td>
</tr>
<tr>
<td>Introduction to Programme, participants, folder contents and announcements</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session-1 Setting the Scene: Country, regional and Global overview of preventing unsafe abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concurrent group sessions</td>
</tr>
<tr>
<td>Presentation: 15 minutes</td>
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<tr>
<td>Discussions: 5 minutes</td>
</tr>
</tbody>
</table>

<p>| SEAR Member States presentations on current situation and opportunities |
|--------------|------------------|------------------|------------------|
| Group-1 | Group-2 | Group-3 | Group-4 |
| Chair: Dr Lakhbir Dhaliwal | Chair: Dr Chiranji Lal | Chair: Dr Sanjeev Kholkute | Chair: Professor Dr Mya Thidar |
| Co-chair: Dr Latifa Shamsuddin | Co-chair: Dr Aanada Ranatunga | Co-chair: Dr Lubna Hassan | Co-chair: Dr Surasak |
| Group Rapporteur: Dr Suneeta Lawrence | Group Rapporteur: Dr Sanghamitra Ghosh | Group Rapporteur: Dr Jyoti Benwari Cambodia | Group Rapporteur: Dr Titut Prihyugiarto |
| Bangladesh | India | Maldives | DPR Korea |
| Bhutan | Nepal | Pakistan | Myanmar |
| Indonesia | Sri Lanka | Timor Leste | Laos |
| | | | Thailand |</p>
<table>
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<tr>
<th>Session 2</th>
<th>Abortions in Adolescents: situation and challenges</th>
<th>Dr Neena Raina</th>
</tr>
</thead>
</table>

**Plenary**

- Group work on Legal and Policy considerations-identify legal and policy barriers
- 4 concurrent Groups
- **Facilitators:**
  - Group 1: Dr Sumithra Tissera
  - Group 2: Ms Medha Gandhi
  - Group 3: Ms Susmita Das
  - Group 4: Ms Rustini Floranita

**Plenary presentation on Group discussions and key observations**
- Group Rapporteurs

<p>| Market Place &amp; WHO Reception | All participants |</p>
<table>
<thead>
<tr>
<th>Agenda Item/Subject</th>
<th>Facilitator/Speaker</th>
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<tbody>
<tr>
<td>Recap/Reflections of Day-1</td>
<td>Participant</td>
</tr>
<tr>
<td>Overview of Chapter 4: Legal and Policy Considerations and Introduction to Human Rights approach</td>
<td>Mr Rajat Khosla</td>
</tr>
<tr>
<td><strong>Panel Discussion on Human Rights and Legal issues</strong></td>
<td>Discussant: Mr Rajat Khosla</td>
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<tr>
<td>Panel:</td>
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<tr>
<td>• Dr Sim-Poey CHOONG, Chair ASAP, Malaysia</td>
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<tr>
<td>• Ms Sapna Pradhan Malla, Lawyer/Advocate, Nepal</td>
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<td>• Dr Kamehang, Thailand</td>
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<tr>
<td><strong>Session-3</strong></td>
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<tr>
<td><strong>Overview of Chapter 2: Clinical Considerations</strong></td>
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<tr>
<td>Process of developing clinical recommendations and reviewing evidence</td>
<td>Dr Natalie Kapp</td>
</tr>
<tr>
<td>Clinical recommendations</td>
<td>Dr Suneeta Mittal</td>
</tr>
<tr>
<td>Panel on challenges for implementing clinical guidelines</td>
<td>Dr Suchitra Dalvie-Moderator</td>
</tr>
<tr>
<td>(Hilary-Gyuniti, Dr Helena-Concept Foundation, Dr Chanda Karki-Nepal, Dr Poonam Shivkumar, India and Dr Rubina Sohail-SAFOG)</td>
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<tr>
<td><strong>Session-4</strong></td>
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<tr>
<td><strong>Overview of Chapter 3: Establishing and Strengthening abortion services</strong></td>
<td>Mr Vinoj Manning</td>
</tr>
<tr>
<td>• Lead Presentation and Group work 1: Evidence based standards and guidelines</td>
<td>Chair: Dr Mohamed Aseel Jaleel, MAL; Presenter: Dr Tapash, Bangladesh; Facilitator: Dr Pratima, India</td>
</tr>
<tr>
<td>• Lead Presentation and Group work 2: Service delivery, setting up, monitoring, equipment and drug availability</td>
<td>Chair: Mr Aboobacker Sddique, India; Presenter Dr Pritha Biswas, MSI; Facilitator: Dr Nadeem Mohamed, IPPF</td>
</tr>
<tr>
<td>• Lead Presentation and Group work 3: Training: Pre/In service, competency based, curricula, assessment and quality assurance</td>
<td>Chair: Dr Ashok Sharma, India; Presenter: Dr Sangeeta, IPAS; Facilitator: Dr Dwiana Ocviyanti, INDO</td>
</tr>
<tr>
<td>• Lead Presentation and Group work 4: Decentralizing abortion services to primary level (Dr Indira, Ipa)</td>
<td>Chair: Mr Sonam Wangdi, BHU, Presenter: Dr Indira IPAS; Facilitator: Dr Tira Aswitama, UNFPA</td>
</tr>
<tr>
<td><strong>Session 5</strong></td>
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<tr>
<td>Plenary presentation on group work</td>
<td>Group Rapporteur</td>
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<tr>
<td><strong>Session 6</strong></td>
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</tr>
<tr>
<td>Establishing Safe Abortion Services in Nepal Introduction to field visit</td>
<td>Government of Nepal National Programme Manager</td>
</tr>
<tr>
<td>Day-3 Wednesday, 19th September</td>
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<tr>
<td><strong>Agenda Item/Subject</strong></td>
<td><strong>Facilitator/Speaker</strong></td>
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<tr>
<td>Field visit</td>
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<tr>
<th>Day-4 Thursday, 20th September</th>
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<tbody>
<tr>
<td><strong>Session-7</strong> Recap/reflections of previous day and field visit</td>
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<tr>
<td>Dr Sanjay Chauhan</td>
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Sharing of Good practices and country experiences in facilitating safe abortion services

<table>
<thead>
<tr>
<th><strong>Agenda Item/Subject</strong></th>
<th><strong>Facilitator/Speaker</strong></th>
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</thead>
<tbody>
<tr>
<td>Decentralization and scale up of abortion services through partnership</td>
<td>Dr Anu Kumar, Ipas</td>
</tr>
<tr>
<td>Best practices on increasing access to Abortion services through Advocacy and Service delivery</td>
<td>Dr. Karthik Srinivasan, IPPF</td>
</tr>
<tr>
<td>Good practices, experiences and challenges from MSI’s programmes in providing safe abortion services across Asia</td>
<td>Dr Bethan Cobley, MSI</td>
</tr>
<tr>
<td>PSI’s commitment to Reducing Maternal Mortality through Safe Abortion</td>
<td>Dr Jyoti Vajpayee, PSI</td>
</tr>
</tbody>
</table>

| **Session-8** Introduction to the Strategic Approach | |
| Discussions | |
| Introduction to group work for country teams: framework for actions on preventing unsafe abortions | |
| Country teams for group work | |

| **Session-9** Group Work | |
| Report on country action plans and regional actions | **Country team representative** |

| **Session 10** Wrap up and next steps | **WCO, SEARO and HQ** |
Annex 18

List of Participants

COUNTRY PARTICIPANTS

**Bangladesh**

1. Dr Md Moinuddin Ahmed  
Program Manager  
CCSDP  
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Kawran Bazar, Dhaka

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Dhaka

3. Prof Latifa Shamsuddin  
Obstetrical and Gynaecological Society of Bangladesh  
Dhaka

**Bhutan**

4. Mr Sonam Wangdi  
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Thimphu

**DPR Korea**

5. Dr Choe Ryon Hui  
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Pyongyang

6. Dr O Hyon A  
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Ministry of Public Health  
Pyongyang

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Medical Termination of Pregnancy Committee  
The Federation of Obstetric and Gynecological Societies of India (FOGSI)  
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**Indonesia**

10. Dr Gita Maya Koemarasakti  
Master of Hospital Administration,  
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Ministry of Health  
Jakarta

11. Dr Dwiana Ocviyanti  
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Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Indonesia  
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Preventing unsafe abortion to reduce maternal mortality
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   Ministry of Public Health  
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21. Dr Chanchai Vantanasiri  
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   Mahidol University  
   Ministry of Education  
   Bangkok

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22. Mrs Antonia Maria do Rego Mesquita Fernandes  
   Emergency Obstetric Care Officer  
   Maternal and Child Health Department  
   Dilli

23. Mrs Gina Maria J da Silva Ximenes  
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37. Mr Rajat Khosala  
   Economic, Social and Cultural Rights Policy Coordinator (Health)  
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39. Dr Sim Poey Choong  
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Cambodia

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Regional Meeting on Preventing Unsafe Abortion to Reduce Maternal Mortality

Kathmandu, Nepal, 17–20 September 2012
A regional meeting on preventing unsafe abortion to reduce maternal mortality was organized in Kathmandu during 17–20 September 2012 to discuss the current global, regional and country situation of abortion services, as well as share and disseminate the updated WHO safe abortion guidelines. Country plans were drafted to promote safe abortion services at this meeting, which will be further refined at the country level to ensure that strategies are adopted and activities carried out to make safe abortion services increasingly available in the Member States of WHO South-East Asia Region.